CAREPATHrx

Home Infusion Therapy (HIT) Skilled Nursing Visit

Today's Date: Start Date: End Date:

Patient Name: _____ **Patient DOB:** _____

Physician's Name: _____ **Allergies:** ☐ NKDA ☐ Allergies Reviewed

☐ Allergies impacting HIT treatment: _____ or ☐ N/A

HIT Medication: _____ **Dose:** _____ **Frequency:** _____

LOT #: _____ **EXP Date:** _____ **Diagnosis(es) requiring HIT Medication:** _____

(Primary Reason for Service)

☐ MD orders reviewed ☐ Pharmacy Plan of Treatment (POT) reviewed **Other Pertinent Diagnosis(es):** _____

IV access: ☐ Central type:_____ Location: _____ Lumens: _____ ☐ Peripheral Guage: _____ Site: _____ # of attempts: _____

Pre-Medications Given:

TIME	MEDICATION	DOSE	ROUTE

Labs: ☐ Drawn per orders and labeled ☐ Will be taken to _____ lab. ☐ Labs drawn outpatient ☐ None Ordered

Vital Signs & Infusion Rate:

TIME	INFUSION RATE	TEMP	PULSE	RESP RATE	BLOOD PRESSURE	SAO2	SIDE EFFECTS/ COMMENTS
	PRIOR TO INFUSION						

Assessment:

Current Weight	Neuro	Cardiac	Edema	Resp
_____ ☐ lbs ☐ kg ☐ Estimated ☐ Patient Reports ☐ Weighed on Scale				

GI	GU	Skin	Pain	Other/ Comments

Next infusion scheduled for: _____ Pharmacy notified of next scheduled visit? ☐ Yes ☐ No

Pharmacy notified of needed supplies for next infusion? ☐ Email ☐ Phone call

Medication changes: ☐ Orders received ☐ Order changes ☐ Pending ☐ None

Care plan updated: ☐ Yes ☐ No

Outcome of visit: ☐ Successful ☐ Unable to infuse medication ☐ Other: _____

Teaching

- ☐ Signs and symptoms of allergic reaction HIT medication.
- ☐ Emergency medication use.
- ☐ Pharmacy and Nursing Agency emergency numbers.

Next MD appointment: _____

Comments/ Notes: