Coram®
CVS specialty infusion services

Nurse Admission Visit Record

Clinical Visit Data

Patient Name:	Patient ID#:	Day:	Date:
	Visit code:	Homebound status: ☐ N/A ☐ Meets criteria ☐ Does not meet criteria	After hours? ☐ Yes ☐ No
Level of service: ☐ 1 ☐ 2A ☐ 5	Activity code:		
Office hours: ______ ☐ none / Other hours: ______ ☐ none	Therapy code:	Odometer start:	Odometer stop:
Labs drawn? ☐ Yes ☐ No / Transplant patient? ☐ Yes ☐ No	Non-bill reason:		
Travel time start: / Visit time start:	Visit time end:	Travel time end:	Total travel time:

Therapy Type/Medical History

Drug #1: ____________ Drug #3: ____________

Drug #2: ____________ Drug #4: ____________

Diagnosis (list all being treated): ____________

Medical and surgical history: ____________

☐ NKDA ☐ Allergies: ____________

Are there any cultural or spiritual needs that will impact your medical care? ☐ No ☐ Yes (list): ____________

Gender: ☐ Male ☐ Female Code status: ☐ Resuscitate ☐ DNR ☐ DNR orders present ☐ DNR orders requested

Patient has Advanced Directives ☐ Yes ☐ No ☐ Copy requested ☐ Copy obtained

Vital Signs/Weight

T: ______ P: ______ R: ______

BP: ______ / ______

Height: ______ Weight: ______ ☐ lbs ☐ kg ☐ N/A

Unintentional weight change: ☐ Yes ☐ No ☐ Dietitian notified

Patient/Home Safety

☐ Physician notified ☐ No deficit noted

☐ Safety concern(s) identified (describe): ____________

☐ Intervention(s): ____________

Patient reports that current medications cause drowsiness or dizziness ____ Yes ____ No

Age > 75 years ____ Yes ____ No History of falls causing injury ____ Yes ____ No

☐ Evacuation process reviewed with AIS patients

Access Device

Catheter present at start of visit: Code	Description	Complete section below for all catheters present at start of visit or placed during visit: Date placed	Code	Description	Location	Size	Lumens	Brand	Placed by: Coram	HHA	MD	Other
#1:									☐ ____(# attempts)	☐	☐	☐
#2:									☐ ____(# attempts)	☐	☐	☐

#1	Insertion site status	#2
☐	No deficit noted	☐
☐	Pain	☐
☐	Erythema	☐
☐	Edema	☐
☐	Streak	☐
☐	Cord	☐
☐	Heat	☐
☐	Sutures	☐
☐	Drainage	☐

#1	Outcome evaluation	#2
☐	No deficit noted	☐
☐	Infiltration	☐
	Grade ☐ 1 ☐ 2 ☐ 3 ☐ 4	
☐	Phlebitis	☐
	Grade ☐ 1 ☐ 2 ☐ 3	
☐	Extravasation	☐
☐	Occluded	☐
☐	Damaged	☐
☐	Suspected infection	☐

#1	Intervention	#2
☐	None	☐
☐	Insertion	☐
☐	Removal	☐
☐	Replace same	☐
☐	Replace different	☐
☐	Access (port)	☐
☐	Deaccess (port)	☐
☐	Repair	☐
☐	Restore patency	☐

Dressing type applied: ☐ N/A ☐ Transparent ☐ Gauze ☐ Other: ____________

Blood return: ☐ Yes ☐ No ☐ Not assessed

Access device was flushed with the following (total):

☐ NS: ____ mL(s) ☐ Heparin: ____ units/mL, ____mL(s)

☐ Injection cap(s) changed ☐ Ext set(s) changed

☐ Securement device chg'd Port needle size: ______

PICC/Midline Assessment ☐ N/A

Upper arm circumference: ______ cm

External catheter length: ______ cm

Tip placement in SVC documented by x-ray ☐ YES (PICC) ☐ N/A (midline)

Nursing Intervention	Labs drawn:	Medication dose calculation verified prior to administration: ☐ Yes ☐ No ☐ NA
	Site: ☐ venipuncture ☐ catheter	Calculation:
	Lab used:	

Respiratory

☐ No deficit noted

☐ Dyspnea: ☐ at rest ☐ on exertion ☐ mild ☐ moderate

☐ Oxygen in use __ l/min: ☐ continuous ☐ prn

☐ Home Oxygen Safety Risk Assessment* See assessment criteria on back of form

☐ Abnormal breath sounds (describe): ____________

☐ Cough: ☐ dry ☐ productive: ____________ (describe)

☐ Other: ____________

Cardiovascular

☐ No deficit noted

☐ Chest pain ☐ Dizziness on rising/sitting up

☐ Heart sounds abnormal ☐ Neck vein distention

☐ Irregular heart rate

☐ Edema: ☐ bilateral ☐ L ☐ R ☐ pitting ☐ location: ____________

☐ Other: ____________

Nurse signature ____________ Coram ID number or agency name

Patient Name: ____ Patient ID#: ____ Date: ____

Gastrointestinal ☐ No deficit noted

Diet: ____
- ☐ Appetite suppressed
- ☐ Abdominal cramps/tenderness or pain
- ☐ Constipation; last BM: ____
- ☐ Diarrhea; #/day: ____
- ☐ Nausea; #/day: ____
- ☐ Enteral tube: ____
- ☐ Other: ____
- ☐ Abdomen distended
- ☐ Heartburn
- ☐ Incontinence
- ☐ BS abnormal
- ☐ Emesis; #/day: ____
- ☐ Ostomy: ____

Genitourinary ☐ No deficit noted
- ☐ Dysuria
- ☐ Cloudy
- ☐ Frequent
- ☐ Foul smelling
- ☐ # Voids/day: ____
- ☐ Other: ____

Musculoskeletal ☐ No deficit noted
- ☐ Muscle cramping ☐ Stiffness
- ☐ Weakness: ____
- ☐ Requires assistance
  - ☐ caregiver ☐ crutches
  - ☐ cane ☐ walker
  - ☐ wheelchair

Gait: ☐ unsteady ☐ shuffling
- ☐ Other: ____

NeuroSensory ☐ No deficit noted
- ☐ Headache ☐ Disoriented ☐ Vertigo ☐ Fatigue
- ☐ Anxious ☐ Memory deficit: ☐ short-term ☐ long-term
- ☐ Numbness/tingling (location): ____
- ☐ Seizures (freq): ____

Vision: ☐ glasses/contacts ☐ legally blind ☐ blurred/double vision
Hearing: ☐ tinnitus ☐ hearing aids needed ☐ deaf
- ☐ Other: ____

Integumentary ☐ No deficit noted
- ☐ Mouth ulcers ☐ Bruising/ecchymosis
- ☐ Hives/rash: ____
- ☐ Wound: Location: ____

Size: ____ ☐ Sutures
- ☐ Drainage: ____
- ☐ Wound vac
- ☐ Wound care performed by: ____
- ☐ Other: ____

Endocrine ☐ No deficit noted
- ☐ Diabetic

FSBS range: ____ ☐ N/A
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Other: ____

Pain ☐ None reported

Site 1: Location: ____ PSR: ____ Acceptable pain level: ____
Site 2: Location: ____ PSR: ____ Acceptable pain level: ____
Current intervention (meds and/or other): ____
Other: ____

Site 1	Qualifiers:	Site 2
☐	Sharp	☐
☐	Dull	☐
☐	Aching	☐
☐	Burning	☐
☐	Tingling	☐
☐	Throbbing	☐
☐	Constant	☐
☐	Intermittent	☐

Pediatric ☐ N/A (patient 14 or older)
Patient age: ____ ☐ **Adult caregiver present**

Children under 2 yrs: Head circumference: ____ ☐ N/A
Anterior fontanel: ☐ open ☐ closed
Posterior fontanel: ☐ open ☐ closed
All children: Child safety measures in place:
☐ YES ☐ none needed ☐ incomplete (comments): ____

Immunizations current: ☐ Yes ☐ No Physician aware ☐ Yes ☐ No
Developmental delay: ☐ No ☐ Yes (describe): ____
Attending school: ☐ Yes ☐ No ☐ N/A
Child's comprehension of disease/prognosis: ☐ good ☐ fair ☐ poor ☐ N/A
Child able to participate in therapy ☐ Yes ☐ No

Patient/Caregiver Teaching

Individuals taught: ☐ Patient ☐ Caregiver: ____ (name/relationship)

Patient/Caregiver able to read and /or verbalize understanding of:
- ☐ Patient/Caregiver role
- ☐ Disease process
- ☐ Patient Resource Guide (PRG) contents
- ☐ Patient education tools
- ☐ Medication information sheets
- ☐ Plan of care
- ☐ Supply Inventory Management
- ☐ Medication profile reviewed/verified with patient/caregiver

Catheter care:
Catheter dressing will be changed by: ☐ N/A ☐ Nurse ☐ Patient/Caregiver ☐ Other: ____

	N/A	Pt/Caregiver observed	Pt/Caregiver demonstrated	Pt/Caregiver independent
Catheter flushing	☐	☐	☐	☐
Catheter dressing change	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐

- ☐ Pt/Caregiver understands frequency and duration of medication: Dose times: ____ Tubing chg frq: ____
- ☐ Pt/Caregiver is able to verbalize why they are receiving infusion services
- ☐ Pt/Caregiver has been taught to remove access device

Therapy specific teaching:
- ☐ Chemotherapy spill kit reviewed
- ☐ Mailback sharps instructions provided
- ☐ Mailback pump instructions provided
- ☐ Scheduled lab work explained

Pump teaching: **Pump:** ____
- ☐ On/Off reviewed
- ☐ Patient/Caregiver can hear alarms
- ☐ Patient/Caregiver can change battery
- ☐ Patient/Caregiver can charge power pack
- ☐ Patient/Caregiver can change medication bag
- ☐ Patient/Caregiver can program pump changes

Pump Programming Verification: ☐ N/A ☐ New Pump Program Verified against Orders/Label ☐ Existing Pump Program Verified Against Label

Additional comments: ____

Next nursing visit: ____ **Next M.D. visit:** ____

Nurse signature ____ ID number/agency name ____ Patient/Caregiver signature (required) ____

☐ Initial Copy
☐ Updated Copy

CORAM.
CVS/specialty infusion services

PATIENT MEDICATION PROFILE

Patient Name:	Pt ID #:	Date:

Allergies/Adverse Reactions (Describe):

☐ Patient Denies OTC, Home Remedies Use ☐ Takes OTC, Home Remedies (see below)

START DATE	MEDICATION	DOSE	ROUTE	*FREQUENCY	D/C DATE	INFO TAKEN BY (non-RPh)	TAKEN BY/ REVIEWED (RPh)

REVIEWING PHARMACIST SIGNATURE(S)	INITIALS	ID#	REVIEW DATE	NON-PHARMACIST SIGNATURE	INITIALS	ID#

☐ Updated profile sent to patient at time of discharge
*Include purpose if medication is ordered PRN

COR55029 Revised: 03/14

CORAM
CVS/specialty infusion services

Date: Page 1 of

Patient: ______ Coram ID: ______ SOC Date: ______

PATIENT DEMOGRAPHICS

Address:			DOB:
City:		State:	Zip:
Diagnosis:	Primary:	Secondary:	
	ICD9 Code:	ICD9 Code:	

MEDICATIONS PROVIDED BY CORAM

Allergy History (List allergen and describe reaction):

Medications:

Flush Access Device: NS: ______ mL(s)/lumen ☐ before and after med administration ☐ prn ☐ ______ mL(s)/lumen post lab draws ☐ Heparin: ______units/mL: ______mL(s)/lumen ☐ after med administration ☐ prn ☐ post lab draws
☐ Other flush solution:

☐ **See current medication profile attached. Physician to review and contact Coram Pharmacy with any inconsistencies.**
☐ **See attached Acute Infusion Reaction Orders.**

ACCESS DEVICE CARE AND MAINTENANCE

Maintain Catheter Access Type:

☐ N/A	☐ PICC	☐ Intrathecal	☐ Implanted pump
☐ Peripheral	☐ Central tunneled	☐ Implanted port	☐ Subcutaneous infusion
☐ Midline	☐ Epidural	☐ Central non-tunneled	☐ Other: ______

☐ If catheter is removed, may replace with: ______
☐ May remove PIV at end of therapy ☐ Remove PIV after each infusion
☐ Replace PIV: ☐ every 72-96 hours ☐ prn complications ☐ maximum of 7 days dwell time
Central Catheter/PICC repair by: ☐ Hospital ☐ Coram Nurse ☐ N/A
☐ May apply heat to treat and/or prevent access device complications
☐ May apply antibiotic ointment after CVC removal
☐ Reaccess port every ______ days or every ______ weeks when not in use
☐ May administer Alteplase 2mg IV prn occluded CVC, and repeat once if needed

Dressing Change: ☐ Transparent every ______ days and prn ☐ Gauze every ______ days and prn
☐ Other: ______

Teach patient/caregiver the following procedures: ☐ Catheter dressing change
☐ Access port ☐ Deaccess port ☐ Remove PIV Other: ______
Medication to be administered by: ☐ Patient/Caregiver ☐ Nurse
☐ Verbal order obtained from prescriber before patient/caregiver independent administration of IVIg

LAB ORDERS

☐ Labs may be drawn from access device
☐ Patient/caregiver may be taught how to draw labs from access device

NURSING VISITS

Nursing Visit Frequency: ☐ Weekly and prn ☐ Other: ______
☐ RN to administer prescribed therapy ☐ Patient may be seen in AIS

MISCELLANEOUS

☐ Diabetic ☐ Other diet restrictions:
Code Status: ☐ Resuscitate ☐ DNR
☐ Enteral Feedings: ______
☐ Wound Care: ______
☐ Other: ______

GOALS AND DISCHARGE PLANS

Goals:
☐ Patient will complete therapy as prescribed, without complications.
Patient specific and measureable goals for this certification period include:
☐ ______
☐ ______

Discharge Plan: ☐ Unknown date ☐ Discharge from services on: ______

© 2008 Coram, Inc. • COR55037-1006

Patient name: ______________________ ID number: ______________________

Rehab Potential	Functional Limitations	Mental Status
☐ Full Recovery ☐ Partial Recovery ☐ No Recovery ☐ Terminal	☐ None ☐ Amputation ☐ Hearing ☐ Speech ☐ Paralysis ☐ Legally Blind ☐ Mental ☐ Contracture ☐ Dysphagia ☐ Other: ______________	☐ Alert/Oriented ☐ Lethargic ☐ Confused ☐ Anxious ☐ Depressed ☐ Comatose ☐ Other: ______________

Activities Permitted	Safety Measures
☐ No Restrictions ☐ Independent at Home ☐ Homebound ☐ Bedbound ☐ Ambulatory ☐ Non-Ambulatory ☐ Complete Bedrest ☐ BRP ☐ Up As Tolerated ☐ Transfer Bed/Chair ☐ Exercise Prescribed ☐ L ☐ R ☐ Partial Weight Bearing ☐ Cane ☐ Wheelchair ☐ Walker ☐ Crutches ☐ Other: ______________	☐ ALLERGIES: ______________ ☐ Environment Safe ☐ Adequate Support System ☐ Safe Disposal of Waste ☐ Adequate Refrigeration System ☐ Patient ☐ Caregiver appropriate/able to learn and ☐ carry out procedures ☐ Other: ______________

Discharge and Referral Plan

Discharge to: ☐ Home ☐ Other facility: ______________

Services required: ☐ Aide ☐ PT ☐ OT ☐ Wound Care

Comments: ______________

Day Summary of Care

☐ N/A (initial POT)

☐ Medication Administration
☐ Access Device Care and Maintenance
☐ Lab Collection
☐ Education to Self-Administer Therapy
☐ Nurse Assessments/Vital Signs
☐ Received Pneumococcal vaccine:
☐ Received Influenza vaccine:

Patient Response to Therapy

Status of symptoms since previous summary: ☐ N/A (initial summary)

☐ Resolved ☐ Improved ☐ Unchanged ☐ Declined

Describe current symptoms of disease process: ______________

Complications of Care

☐ None ☐ Adverse drug reaction ☐ Compliance issues
☐ Access device complications ☐ Missing doses of medication
☐ Hospitalizations (provide date(s) and reason(s)):
☐ Other: ______________

Describe complications checked above: ______________

Verbal/Fax orders reviewed with clinical team on: ______________ (Date) ______________ (Clinician Signature)

Certification Period: ______________ to ______________ ☐ Initial Certification ☐ Recertification

I hereby certify that the above infusion and services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed. An infusion pump and all supplies may be provided as required for the administration of the above prescribed therapies.

Physician Name Physician Address

Physician Phone Physician Fax

X ____

Physician Signature Date

© 2008 Coram, Inc. • COR55037-1006