Coram®
CVS specialty infusion services

Nurse Visit Record
Clinical Visit Data

Level of Service: ☐ 1 ☐ 2A ☐ 5

Patient Name: | Patient ID#: | Day: | Date:

Homebound Status: ☐ N/A ☐ Meets criteria ☐ Does not meet criteria | After Hours? ☐ Yes ☐ No | Visit Code: | Hospitalized Since Last Visit? ☐ Yes ☐ No | Hosp.Dates: ______

Has catheter been removed or replaced since last visit? ☐ Yes ☐ No | Activity Code: | Reason: ______

Office Hours: ______ ☐ none | Other Hours: ______ ☐ none | Therapy Code: | Odometer Start: | Odometer Stop:

Labs Drawn? ☐ Yes ☐ No | Transplant Patient? ☐ Yes ☐ No | ☐ Non-billable ☐ Non-bill Reason Code: ______

Travel Time Start: | Visit Time Start: | Visit Time End: | Travel Time End: | Total Travel Time:

Therapy Type

Drug #1: ______ Drug #3: ______
Drug #2: ______ Drug #4: ______
Diagnosis (list all being treated): ______

Vital Signs/Weight

T: ______ P: ______ R: ______
BP: ______/______
Weight: ______ ☐ lbs ☐ kg ☐ N/A
Unintentional weight change:
☐ Yes ☐ No ☐ Dietitian notified

Medication Update

☐ Medication profile reviewed
☐ no changes ☐ changes listed below
☐ Medication profile not available for review
Change #1: ______
Change #2: ______
Change #3: ______
Other: ______
Patient has Acute Infusion Reaction medications ☐ N/A ☐ Yes ☐ None are expired
(any expired medications need to be replaced and RPh notified)

Teaching and Compliance

Patient/caregiver administers therapy as ordered: ☐ Yes ☐ No ☐ N/A
☐ Intervention (describe): ______
☐ Additional training provided: ______

Patient/Home Safety

☐ **Evacuation process reviewed with AIS patient** ☐ **No deficit noted**

☐ Safety concern identified (describe): ______
☐ Intervention: ______
☐ Physician/other notified: ______

Access Device

Catheter present at start of visit		If the catheter has been removed/replaced or the patient has been hospitalized since the last visit, complete the section below							Placed by:			
Code	Description	Date Placed	Code	Description	Location	Size	Lumens	Brand	Coram	HHA	MD	Other
#1:									☐ ____(# attempts)	☐	☐	☐
#2:									☐ ____(# attempts)	☐	☐	☐

#1	Insertion Site Status	#2	#1	Outcome Evaluation	#2	#1	Intervention	#2
☐	No Deficit Noted	☐	☐	No Deficit Noted	☐	☐	None	☐
☐	Pain	☐	☐	Infiltration	☐	☐	Insertion	☐
☐	Erythema	☐		Grade ☐ 1 ☐ 2 ☐ 3 ☐ 4		☐	Removal	☐
☐	Edema	☐	☐	Phlebitis	☐	☐	Patient Removal ______ (date)	☐
☐	Streak	☐		Grade ☐ 1 ☐ 2 ☐ 3 ☐ 4		☐	Replaced Same	☐
☐	Cord	☐	☐	Extravasation	☐	☐	Replaced Different	☐
☐	Heat	☐	☐	Occluded	☐	☐	Access (port)	☐
☐	Sutures	☐	☐	Damaged	☐	☐	Deaccess (port)	☐
☐	Drainage	☐	☐	Suspected Infection	☐	☐	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)
☐ Ext set(s) changed ☐ Injection cap(s) changed
☐ Securement device chg'd Port needle size: ______

PICC/Midline Assessment:
☐ Upper arm circumference ______ cm
☐ External catheter length ______ cm

Nursing Interventions

☐ Lab tests drawn: ______
Lab used: ______ ☐ venipuncture ☐ catheter
☐ Implanted pump refill ☐ Supply inventory ☐ Other: ______

Response to Therapy

☐ **Care plan reviewed**

Symptoms: ______
☐ Resolved ☐ Improved ☐ Unchanged
☐ Declined ☐ Physician notified: ______
Care plan chg: ______

Nurse signature

Coram ID # or Agency Name

Clinical Record

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
☐ Heart sounds abnormal
☐ Irregular heart rate
☐ Edema: ☐ bilateral ☐ L ☐ R ☐ pitting ☐ location: ___
☐ Dizziness on rising/sitting up
☐ Neck vein distention
☐ Other: ___

Gastrointestinal ☐ No deficit noted

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

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 years or older)
☐ Adult caregiver present (patient under the age of 18 years)

Children under 2 yrs: Head circumference: ___ ☐ N/A
Anterior ☐ open ☐ closed Posterior ☐ open ☐ closed
All children: Current height: ___
Child safety measures in place:
☐ yes ☐ none needed ☐ incomplete (see comments): ___
Any immunizations since last visit: ☐ No ☐ Yes (list): ___
Any school absences since last visit: ☐ Yes: # ___ ☐ No ☐ N/A

Medication Administration ☐ N/A **Medication dose calculations verified prior to administration** ☐ Yes ☐ No ☐ N/A

Calculations:

Med administered: ___ ☐ Additional monitoring not required

Time	Rate	Vital signs	Patient response

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 Coram ID # or Agency Name Patient signature