COUNTY HOSPITAL HOME HEALTH
INFUSION NURSE NOTE

INFUSION Patient Name ______________________________ MR # ____________

☐ Peripheral - gauge / site ______________________________ Date: ____________________

☐ Picc - gauge / site ______________________________ ☐ Single Lumen ☐ Double Lumen

☐ Central ☐ Mid-Line ☐ Mid-Clavicular

☐ Single Lumen ☐ Double Lumen ☐ Triple Lumen

☐ Date of Placement ______________________ ☐ X-Ray Verification Yes___ No___

☐ Mid Arm Circumference __________ in / cm ☐ External Catheter Length __________ in / cm

☐ Hickman ☐ Broviac ☐ Groshong ☐ Jugular ☐ Subclavian

☐ Single Lumen ☐ Double Lumen ☐ Triple Lumen

☐ Epidural Catheter ☐ Tunneled ☐ Port

☐ Implanted Vascular Access Device ☐ Venous ☐ Arterial ☐ Peritoneal

☐ Medication: Name of Drug _________________________ Dose ______________________________

Route ________________________________ Frequency __________________________

☐ Pump __________________ ☐ Intermate ☐ IV Tubing

Administered By: ☐ Self ☐ Caregiver ☐ RN

☐ Medication: Name of Drug _________________________ Dose ______________________________

Route ________________________________ Frequency __________________________

☐ Pump __________________ ☐ Intermate ☐ IV Tubing

Administered By: ☐ Self ☐ Caregiver ☐ RN

☐ Medication: Name of Drug _________________________ Dose ______________________________

Route ________________________________ Frequency __________________________

☐ Pump __________________ ☐ Intermate ☐ IV Tubing

Administered By: ☐ Self ☐ Caregiver ☐ RN

☐ Medication: Name of Drug _________________________ Dose ______________________________

Route ________________________________ Frequency __________________________

☐ Pump __________________ ☐ Intermate ☐ IV Tubing

Administered By: ☐ Self ☐ Caregiver ☐ RN

☐ Flushing Protocol / Frequency: Circle all that apply

_____ ml Normal Saline	_____ ml Sterile Water	_____ ml Heparin _______ units / ml
before / after meds	before / after meds	before / after meds
before / after labs	before / after labs	before / after labs
line maintenance	line maintenance	line maintenance

Purpose of Intravenous Access:

☐ Antibiotic Therapy ☐ Chemotherapy ☐ Hydration ☐ Pain Control

☐ Maintain Venous Access ☐ Parenteral Nutrition ☐ Other_____

☐ Site Care _____

☐ Frequency _____

☐ Dressing Change ☐ Sterile ☐ Clean

☐ Needle Change _____

_____

☐ # of Attempts at Restart_____

☐ Labs Drawn_____

☐ Pump / Line Free Flow Protected

☐ Sound of Pump Alarm heard by patient / caregiver from the next room

Assess and Circle Response

Obstructed / Clotted Device	Yes	No
Infiltrated / Dislocated Device	Yes	No
Edema of Site	Yes	No
Drainage of Site	Yes	No
Vein Thrombosis / Thrombophlebitis	Yes	No
Faulty Infusion Pump / Controller	Yes	No
Redness of Site	Yes	No
Temperature > 101 degrees F	Yes	No
Cultures Performed	Yes	No

Site / # _____

☐ Interventions / Instructions _____

_____

_____

_____

_____

_____ _____

Patient's Signature Date Nurse's Signature Date