Specialty Pharmacy Nursing Network
1800 2nd Street Suite 720
Sarasota, FL 34236
Phone: (877) 330-7766

Visit Verification Form

Patient Name: _____ **DOB:** _____ **Visit Date:** _____

Visit Information

Visit Start Time: _____ **Finish Time:** _____ **Total Time:** _____

Next Scheduled Visit Date: _____ ☐ **Not Applicable**

Has pharmacy changed since last visit? □ No □ Yes (please list ***new*** provider) _____

Has insurance changes since last visit? □ No □ Yes (please list ***new*** provider) _____

Services Rendered:	**Clinical Trial Research Nurses Only**	**Total Hours**	**Est**
☐ Self-Administration Teaching	☐ ICG-GCP	_____	0.5 h
☐ Injection Teaching	☐ IATA	_____	0.5 h
☐ Periodic Visit	☐ Nursing Protocol	_____	0.5 h
☐ Infusion Administration	☐ Documentation	_____	1 h
☐ Missed Visit	☐ Other:_____	_____	
☐ Lab Draw			
☐ Other:_____			

To Assignment:

Travel Time: Start: _____ **Finish:** _____ **Total:** _____

Mileage: Start: _____ **Finish:** _____ **Total:** _____

From Assignment:

Travel Time: Start: _____ **Finish:** _____ **Total:** _____

Mileage: Start: _____ **Finish:** _____ **Total:** _____

Fax all documentation forms within 48 hours of visit

Specialty Pharmacy Nursing Network, Inc.
1800 2nd Street, Suite 720, Sarasota, FL 34236
Phone: (877) 330-7766

Patient or Guardian and Nurse Signatures are Mandatory.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Guardian Name: _____ **Guardian Signature:** _____ **Date:** _____

Nurse Name: _____ **Nurse Signature:** _____ **Date:** _____

Clinical Visit Record

Specialty Pharmacy Nursing Network
1626 Barber Road, Suite B
Sarasota, FL 34240
Phone: (877) 330-7766 ♦ Fax: (941) 366-7361

Patient Name: _____ **DOB:** _____ **Visit Date:** _____

Visit Start Time: _____ **Visit End Time:** _____ **Next Scheduled Visit:** _____

Weight: _____lb ☐ **Stable** ☐ **Loss:** _____lb ☐ **Gain:** _____lb **Allergies:** _____

CLINICAL REVIEW OF SYSTEMS

WNL (Within Normal Limits)

Neurologic/Mental Status
- ☐ WNL
- ☐ Disoriented
- ☐ Lethargic
- ☐ Impaired
- ☐ Learning
- ☐ Headache/ Migraine
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Dizziness
- ☐ Syncope
- ☐ Weak Hand Grip ☐ R ☐ L
- ☐ Other_____

Sensory
- ☐ WNL
- ☐ Impaired Speech
- ☐ Dysphagia
- ☐ Blindness ☐ R ☐ L
- ☐ Cataracts ☐ R ☐ L
- ☐ Glaucoma ☐ R ☐ L
- ☐ Glasses
- ☐ Contacts
- ☐ Impaired Hearing ☐ R ☐ L
- ☐ Deaf ☐ R ☐ L
- ☐ Hearing aids ☐ R ☐ L
- ☐ Other_____

Musculoskeletal
- ☐ WNL
- ☐ Impaired Balance
- ☐ Unsteady Gait
- ☐ Decreased ROM
  - ☐ RUE ☐ RLE ☐ LUE ☐ LLE

Weakness/Paralysis
- ☐ RUE ☐ RLE ☐ LUE ☐ LLE
- ☐ Easily Fatigued
- ☐ Assisted Ambulation
- ☐ Dependent Ambulation
- ☐ Assistive Devices:
  - ☐ Wheelchair ☐ Walker
  - ☐ Crutches ☐ Cane
- ☐ Other _____

Endocrine
- ☐ WNL
- ☐ Type I Diabetes
- ☐ Type II Diabetes ☐ NIDDM ☐ IDDM
- ☐ Recent Blood Glucose:_____
- ☐ Other:_____

Respiratory
- ☐ WNL
- ☐ Rales
- ☐ Rhonchi
- ☐ Wheeze
- ☐ Ronchi
- ☐ Productive Cough
- ☐ Non-Productive Cough
- ☐ Shortness of Breath
- ☐ Dyspnea Upon Exertion
- ☐ Oxygen _____LPM
- ☐ Other:_____

Cardiovascular
- ☐ WNL
- ☐ Murmur
- ☐ Chest pain
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ Hypotension
- ☐ Edema
  - ☐ RUE _____ ☐ RLE _____
  - ☐ LUE _____ ☐ LLE _____
- ☐ Other_____

Gastrointestinal
- ☐ WNL
- ☐ Special Diet _____
- ☐ Inadequate Nutrition
- ☐ Inadequate Hydration
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Distension
- ☐ Tenderness
- ☐ Firm
- ☐ Bowel Sounds:
  - ☐ Hyper ☐ Hypo ☐ Absent
- ☐ Other:_____

Genitourinary
- ☐ WNL
- ☐ Burning
- ☐ Increase Frequency
- ☐ Decrease Frequency
- ☐ Incontinence
- ☐ Dialysis
- ☐ Other_____

Integumentary
- ☐ WNL
- ☐ Pallor
- ☐ Cyanosis
- ☐ Jaundice
- ☐ Poor Turgor
- ☐ Rash/ Itching
- ☐ Bruising
- ☐ Lesions
- ☐ Dry/ Scaly
- ☐ Redness
- ☐ Other:_____

Psychosocial
- ☐ WNL
- ☐ Lives Alone
- ☐ Signs and Symptoms of Depression
- ☐ Anxious
- ☐ Inadequate Support Systems
- ☐ Signs and Symptoms Abuse/ Neglect
  - ☐ Contact SPNN
- ☐ Other_____

Pain
- ☐ No Pain Reported
- ☐ **Site 1:** _____
  - Scale (0-10)_____
  - Description_____
  - Frequency _____
- ☐ **Site 2:** _____
  - Scale (0-10) _____
  - Description _____
  - Frequency _____

Response to Therapy
- ☐ No Complications During Administration
- ☐ Complications: See Progress Note

Signs and Symptoms of Disease:
- ☐ Improved
- ☐ Worsened
- ☐ No change

Patient Education
- ☐ Disease process
- ☐ Signs and symptoms of infection
- ☐ Signs and symptoms of administration complications
- ☐ Safety measures
- ☐ Fall prevention
- ☐ When to call the doctor or 911

Nurse Name: _____ **Nurse Signature:** _____ **Date:** _____

Specialty Pharmacy Nursing Network
1626 Barber Road, Suite B
Sarasota, FL 34240
Phone: (877) 330-7766 ♦ Fax: (941) 366-7361

Clinical Visit Record

Patient Name: _____ **DOB:** _____ **Visit Date:** _____

IV Access:

Type: ☐ N/A ☐ PIV ☐ PICC ☐ Hickman/ Broviac ☐ Port ☐ Subcutaneous # of sites_____ ☐ Other: _____ # lumens: _____

Location: _____ **Site Care**: ☐ Aseptic ☐ Sterile **Blood Return:** ☐ Yes ☐ No **Flushes Easily:** ☐ Yes ☐ No

Site: ☐ Clean ☐ Dry ☐ Redness ☐ Edema ☐ Tenderness ☐ Other: _____ **Dressing Change:** ☐ No ☐ Yes **Date due:** _____

Maximum 3 Attempts ☐ N/A Patent Access in Place

Attempt 1: ☐ Butterfly ☐ Angio ☐ Huber **Site:** _____**Size:** _____gauge _____inches ☐ Removed ☐ Complication: _____

Attempt 2: ☐ Butterfly ☐ Angio ☐ Huber **Site:** _____**Size:** _____gauge _____inches ☐ Removed ☐ Complication: _____

Attempt 3: ☐ Butterfly ☐ Angio ☐ Huber **Site:** _____**Size:** _____gauge _____inches ☐ Removed ☐ Complication: _____

IV Status: ☐ Removed/ Infusion Complete ☐ Dressing Applied ☐ No Complication ☐ Left in place for infusion greater than 1 day

Labs Drawn: _____ **Drawn from:** _____ **Sent to/ Delivered to:** _____

Medication Administration:

Pre-Medications: Benadryl ____ mg □ PO □ IV Push □ IV Diluent _____Volume_____ Rate_____ Tylenol: _____mg □ PO □ IV
Other: _____

Medication: _____ **Dose:** _____ **Volume**: _____ **Via:** ☐ Gravity ☐ Rate Tubing ☐ Pump: _____

Hydration: ☐ **N/A** ☐ **Normal Saline** ☐ **D5W** _____ml ☐ Pre Infusion Total Time: _____ ☐ Post Infusion Total Time: _____

Flush: ☐ **Normal Saline** ☐ **D5W** _____ml: ☐ Pre Infusion ☐ Post Infusion ☐ **Heparin** _____units/ ml _____ml ☐ Prior to de-access

Medication Administration Start Time: _____ **Stop Time:** _____ **Total Time:** _____

Lot#:_____ Exp Date: _____	Lot#:_____ Exp Date: _____	Lot#:_____ Exp Date: _____	Lot#:_____ Exp Date: _____	Lot#:_____ Exp Date: _____

	Time	B/P	Temp.	Pulse	Resp.	Infusion Rate	Patient Status
Baseline							
15 min							
30 min							
45 min							
60 min							
2 hours							
3 hours							
4 hours							
5 hours							
6 hours							
7 hours							
8 hours							

Medication changes: ☐ No ☐ Yes – document changes on Patient Medication Profile **Additional Comments**: ☐ See Progress Note

Communication with SPNN: ☐ No ☐ Yes ☐ Adverse Event ☐ Product Quality ☐ Issue/ Complication_____

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Nurse Name: _____ **Nurse Signature:** _____ **Date:** _____