NuFACTOR Specialty Pharmacy

NURSING NOTE

VISIT NOTE MUST BE SUBMITTED TO NUFACTOR WITHIN 14 DAYS.
INVOICE MUST BE SUBMITTED TO NUFACTOR WITHIN 30 DAYS. (Fax to 1.855.553.6922)
For questions, call 1.800.323.6832

Visit Date	__/__/____ MONTH DAY YEAR	**Total Time**	
Time In	☐ AM ☐ PM	**Time Out**	☐ AM ☐ PM
Client Name	First Name Last Name	**DOB**	__/__/____ MONTH DAY YEAR
Primary Diagnosis		**ICD10**	
Secondary Diagnosis		**ICD10**	

Check the box that best describes the patient assessment. **All abnormalities require further documentation.**

☐ Initial Assessment ☐ Follow up Visit ☐ Reassessment

Patient assessment: Review of systems

Baseline Vital Signs

T P RR
BP /
Weight ☐ LB ☐ KG
☐ Gain ☐ Loss ☐ Same

Cardiovascular

☐ WNL ☐ Hypertension
☐ Chest Pain ☐ Hypotension
☐ Edema ☐ Arrhythmia
☐ Other (note below)

Respiratory

☐ WNL ☐ Dyspnea
☐ Cough
☐ Abnormal lung sounds
☐ Other (note below)

Gastrointestinal/Nutrition/Integumentary

☐ WNL ☐ Diarrhea ☐ Poor dietary compliance
☐ Nausea ☐ Constipation ☐ Dry mucous membranes
☐ Vomiting ☐ Poor skin turgor ☐ Difficulty swallowing
☐ Other (note below) ☐ Inadequate fluid intake

Genitourinary

☐ WNL ☐ Urgency
☐ ↑ Frequency ☐ Abnormal color
☐ ↓ Frequency
☐ Other (note below)

Neurologic/Musculoskeletal

☐ WNL ☐ Numbness ☐ Cramping
☐ Confused ☐ Tingling ☐ Muscle twitch
☐ Forgetful ☐ Weakness ☐ Difficulty speaking
☐ Other (note below) ☐ Nasal/slurred speech

Endocrine

☐ WNL
☐ Diabetic
☐ Other (note below)

Activity

☐ WNL ☐ Wheelchair
☐ Bedbound ☐ Cane
☐ Walker
☐ Other (note below)

Psychosocial

☐ WNL
☐ Inadequate support system
☐ Caregiver unavailable
☐ Other (note below)

Home Environment / Safety

☐ WNL
☐ Fall risk
☐ Other (note below)

Pain

Pain Level (0 - 10): _____ ☐ Sharp ☐ Dull
☐ Ache ☐ Constant ☐ Intermittent
☐ Location _____
☐ Current intervention _____

Assessment

IV access (Obtain access prior to spiking vial)

☐ Peripheral ☐ L ☐ R ☐ Hand ☐ Forearm ☐ Antecubital ☐ Other: _____
☐ Central Line ☐ Tunneled ☐ Implanted ☐ PICC Location: _____

Needle Type Gauge Length # of attempts
☐ Flushes without resistance ☐ Positive blood return ☐ Flushed per protocol/orders

Site Assessment ☐ Normal ☐ Pain ☐ Redness ☐ Swelling ☐ Flare/Streaking ☐ Irritation
☐ Infiltration ☐ If PIV or PAC in place, WNL? ☐ Y ☐ N

IV Flush ☐ NS mL ☐ Heparin units/mL mLs

Subcutaneous access (SCIG or HyQvia)

injection sites Location of sites
☐ No blood return If site reactions, please describe

RN Name: **Date:**
RN Signature: Digitally Signed ☐

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Drug			
	☐ Bivigam 10%	☐ Flebogamma DIF 5%	☐ Flebogamma DIF 10%
	☐ Gammaked 10%	☐ Gammagard Liquid 10%	☐ Gammaplex 5%
	☐ Gamunex C 10%	☐ Hizentra 20% (SC Only)	☐ HyQvia (SC only)
	☐ Octagam 5%	☐ Octagam 10%	☐ Privigen 10%
	☐ Carimune NF %	☐ Gammagard SD LIGA %	☐ Other _____

Dose Grams in mL Day of

Premedication

	Drug	Dose	Route	Time	Drug	Dose	Route	Time
☐	None				☐ Ibuprofen			
☐	Acetaminophen				☐ Aspirin			
☐	Diphenhydramine				☐ Solu Medrol			
☐	Loratadine				☐ Solu Cortef			
☐	Zofran				☐ Other:			

☐	**Hydration**	☐ Pre ☐ Post ☐ Concurrent	Fluid ☐ D5W ☐ NS ☐ Other:
		Volume mL Rate: mL/hr	Infusion Start Time

Reaction/Side Effect History - Check all that apply

☐ N/A - Naïve ☐ None ☐ Headache ☐ Fever ☐ Chills ☐ Nausea ☐ Vomiting ☐ Rash ☐ Hypotension
☐ Hypertension ☐ Pain/Myalgia ☐ Other: _____

Infusion documentation

Time	Rate	Temp	HR	RR	Blood Pressure	Comments
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	
	mL/hr				/	

Any adverse events during infusion?	☐ Y ☐ N	Was infusion slowed/stopped due to ADR?	☐ Y ☐ N
Was the infusion completed?	☐ Y ☐ N	If no, amount infused	_____
Was NuFACTOR notified of ADR/infusion interruption? (1.800.323.6832)		☐ Y ☐ N	

Summary of infusion

RN Name:		**Date:**	
RN Signature:		Digitally Signed ☐	

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Response to therapy			
Symptoms	☐ Improved	☐ Unchanged	☐ Deteriorated
Progress toward goals	☐ Good	☐ Fair	☐ Poor

Allergies

Affix lot# and exp tab(s) from vial(s)

Additional Notes

RN Name:		**Date:**	
RN Signature:		Digitally Signed	☐

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Medication Profile

Complete on day 1 for each course of therapy. If there are no changes on subsequent days during the same course of therapy document no changes. If there are changes from day 1, document the complete medication profile again including the change.

Medication name	Dose	Frequency	Date started

RN Name:		**Date:**	
RN Signature:		Digitally Signed ☐	

Next scheduled visit date:		**Scheduled visit time:**	

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