Coram®
CVS specialty® infusion services

Ruconest® Visit Record

Patient ID:	Patient Last Name	Patient First Name	Date of Visit	Shift

DOB	Visit Category	Service Code	Service Description

Homebound Status: ☐ N/A ☐ Meets criteria ☐ Does not meet criteria	*Homebound Status Description*

Vital Signs and Weight			Travel Time Start	Visit Time Start	Visit Time End	Travel Time End	Total Travel Time
Temp	Pulse	Respiration					

Blood Pressure	_____/_____ ☐ N/A	Odometer Start	Odometer End	Total Mileage
Weight			Gender: ☐ Male ☐ Female	

Patient Data

Caregiver:	Relationship:

Therapy Data

Primary Diagnosis:	ICD 10 Code:	Date of Onset
Secondary Diagnosis:	ICD 10 Code:	Date of Onset
Primary Therapy:		Start Date:
Secondary Therapy:		Start Date:

History Relevant to Care:

Objective of Care

Purpose for visit:** (Please select from the drop down list)***

☐ Completion of therapy without complications	☐ Independence of client

Pediatric **Age _____** ☐ **N/A Pt 14 yrs or older** ☐ **Adult caregiver present**

Children under 2 yrs: Head circumference _____ ☐ N/A	Immunizations current: ☐ Yes ☐ No Physician aware: ☐ Yes ☐ No
Anterior Fontanel ☐ Open ☐ Closed Posterior Fontanel ☐ Open ☐ Closed	Developmental delays: ☐ Yes ☐ No
All children: Safety measures in place: ☐ Yes ☐ None needed ☐ Incomplete	Childs comprehension of disease/prognosis: ☐ good ☐ fair ☐ poor ☐ N/A

Comments:

Visit Outcome:

☐ Ongoing Nursing Visits will be provided by Coram (if checked complete a medication profile) Next Visit Scheduled for:

☐ Patient / Caregiver independent with care (No additional Nursing visits required)

Patient Response to Therapy:

☐ N/A

Nurse ID: _____ **Nurse Name:** _____

Patient / Caregiver Signature	**Date**	**Clinician's Signature**	**Date**

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Nurse EID: _____ **Nurse Name:** _____

Ruconest® Patient Visit Form

Patient ID:	Hub ID:	Patient Name:
Male / Female:	Is Patient Pregnant?	Episode Date:
Allergies:		
Location of Treatment:		Medication Administered by:
Purpose of Visit: ☐ Training ☐ Scheduled Dose ☐ On Demand ☐ Training and Infusion		

Visit Information

Date / Time of Symptom Onset:		**Ruconest® Information**		
Time Patient called for nurse:		Dosage:_____ Dose (50 International Units/kg, max of 4200 International Units /dose)		
Time of Nurse arrival:			Vial Lot#	
Nurse Response Time:			Stored Properly	
Time of First Dose:		Number of Doses used (select one)		
Time of Symptom Relief Dose 1:		#1 Lot#_____	#2 Lot #_____	
Time of Dose 2: (if necessary)		Properly disposed of:		
Time of Symptom Relief Dose 2:		Quantity on hand:	Vials	
Time of Nurse Departure:		Alternate Therapy Used:		

Access Management		**Education and Safety Information**	
Number of Attempts:		Reviewed Drug Package Insert with Patient:	
Peripheral IV Location:	Central Line:	Reviewed Side Effects with Patient:	
☐ Left ☐ Right	☐ Port	Informed patient of support services:	
☐ Hand	☐ PICC	Reviewed Emergency Care plan:	
☐ Forearm	☐ Antecubital (left)	If the answer is no to any of the questions above please explain:	
☐ Antecubital	☐ Antecubital (right)		
☐ Other			

Attack Information

Attack location: (choose all that apply)	☐ Hands/Wrists ☐ Legs ☐ Buttocks ☐ Throat/Larynx ☐ Feet/Ankles ☐ Face ☐ Abdomen ☐ Genitals ☐ Arms ☐ Tongue ☐ Neck ☐ Other _____

Severity scale: 0 = None, 1 = Mild, 2 = Mild/Moderate, 3 = Moderate, 4 = Moderate/Severe, 5 = Severe

Severity of attack prior to treatment:	Severity of prior Attacks:
Regular Triggers:	
Any new Triggers for this attack:	Describe:
Number of Attacks this year:	Hx of thrombolytic/embolic event:
Previous HAE hospitalization in the past year:	Date of previous attack:

Briefly explain the problems or issues managing HAE attacks.

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Nurse EID: _____		Nurse Name: _____	
Assessment			
Pre-Infusion: HR:_____	BP: _____	Pain scale: _____	
Location/Quality of Pain:			
Pre-Infusion Swelling: (1,2 or 3)		Swelling Scale: 1=no swelling; 2=moderate swelling; 3=severe swelling	
Post-infusion #1: HR:_____	BP: _____	Pain scale: _____	
Post-infusion #2: HR:_____	BP: _____	Pain scale: _____	
Post-Infusion Swelling: (1,2 or 3)		Swelling Scale: 1=no swelling; 2=moderate swelling; 3=severe swelling	
Severity of Attack after treatment:			
Recommendation		***Next Steps***	
Patient Readiness to self-administer:			
Date for self-infusion training:		Date for self-infusion re-training:	
Barrier(s) to self-infusion training:			
Safety steps: Explain to the patient if they experience laryngeal swelling, they should go immediately to the emergency department. Encourage the patient to call 855-613-4423 for any non-emergent questions or concerns.			
Additional Comments:			
MD Information			
MD Name	First name	Last Name	Title	MD NPI Number
MD Address 2				
MD City	State	ZIP	Phone	