WELCOME

Our Goals:
- To meet all needs of patients requiring Specialty Infusion Services
- To provide “Patient Centric” Care which addresses Clinical, Medical, Social and Emotional aspects of the infusion therapy
- To ensure open communication and ultimate satisfaction of our patients with their Care Team
- To maximize the patient experience in both quality of care and outcomes management
- To always strive to provide excellence in all that we do

Our Promise:
- We are committed to the best quality care and clinical protocols
- We will ensure you, as the patient, are involved in the development of your care plan
- We will improve continuously and grow our program to be the best available for all stakeholders
- We will always monitor and ensure appropriate utilization to optimize results
- We will respect your privacy, dignity, and choices throughout the delivery of care in your setting
- We will respond to any inquiry from you, your support group, and caregivers in a confidential, timely and professional manner.

If you have any questions regarding your care, do not hesitate to call HomeCare Rx at the numbers below:

Business, Co-Pay, Coverage & Delivery: (877) 920-2090
Nursing/Pharmacy (24hours x7 days/week) (877)-822-9240
PATIENT’S RIGHTS & RESPONSIBILITIES

As a patient you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. To participate in the selection of your home care provider, to communicate with them in a language or form you can understand prior to service.
3. Receive competent, individualized care and service regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
4. Be treated with dignity, courtesy, consideration, respect and have your property treated with respect.
5. Be informed verbally and in writing in the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before it is initiated. To be informed of any changes in in the sources of payment and your financial responsibility as soon as possible but no later than thirty (30) days after the provider is notified.
6. Be informed both orally and in writing, in advance of the Plan of Care, of any changes in the Plan of Care, and to be included in the planning of care before treatment begins of all treatment prescribed, when and how services will be provided and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
7. Participate in the planning of your care and be advised of any changes to the Plan of Care and to be transferred to another organization and/or be informed of impending discharge from service, as well as any continuing care needs or services, in a timely manner, as your condition progresses or changes.
8. To receive training in the prescribed home therapy to include:
   a. Reasons for treatment and use supplies and equipment.
   b. Possible risks and side effects of treatment.
   c. Written instructions and demonstration by a registered nurse.
   d. Supervision by a registered nurse until you are able to perform required tasks safely.
9. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an Advance Directive, “Living Will” durable power of attorney and other directives about your care consistent with applicable laws.
10. To receive an appropriate assessment of pain and management of pain.
11. Receive information regarding community resources and be informed of any financial relationships between Home Rx Inc. and other providers to which you may be referred by the agency.
12. Be informed of the procedures for submitting patient complaints, voice complaints and recommend changes in the policies to Patient Services by calling 877-920-3940. If dissatisfied with the outcome you may also contact the New Jersey State Department of Health or any outside agent of the patient’s choice. The expression of any such complaints by the patient shall be free from interference, coercion, discrimination or reprisal.
13. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services and to expect the agency to investigate such complaints within 15 days of receipt. Also, if dissatisfied with the outcome, may submit an appeal to the agency’s governing authority which will be reviewed within 30 days of receipt.
14. To be informed of any alternatives to your prescribed treatment and any risks and benefits associated with the alternatives.
15. To be allowed to participate (or not) in any investigational studies relevant to your diagnosis, after being informed of the risks and benefits of the treatment.
16. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
17. Privacy including confidential treatment of records, and access to your health records on request. Information will not be released without your written consent except in those instances required by law regulation or third party reimbursement.
18. In the situation when the patient lacks capacity to exercise rights, the rights shall be exercised by an individual guardian or entity legally authorized to represent the patient.

As a Home Care Patient, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis and share complete and accurate health information regarding your medical history, condition and response to treatment.
2. Participate in the planning of and be responsible for following the recommended plan.
3. Carry out your therapy as instructed and make it known if you do not understand or cannot follow the treatment plan.
4. Cooperate with agency staff and not discriminate against staff. Be available to co. staff for delivery and nursing visits.
5. Notify the Home Infusion Provider in advance when you cannot keep an appointment.
6. Maintain a safe home setting for storage of medication, administration of care and maintain confidentiality of any and all medical documents that may be left in the home.
7. Notify the agency in the event of readmission to hospital, out-of-town plans or changes in address/phone.
8. Be responsible for your actions if you refuse treatment or do not follow the agency’s recommendations.
9. Take responsibility for financial obligations of your care.

Patient/Representative Signature ___________________________ Date ___________
**Advance Directives**

**Patient Name:**

**Nursing Supervisor:**

**Patient's Rights/Policy Explained:**

**Date:**

**Explained By:**

**DNR:**

☐ Yes  ☐ No  **Date:**

**Location:**

**Reviewed:**

**Cancelled (Date):**

**Home Care Proxy:**

☐ Yes  ☐ No  **Date:**

**Location:**

**Reviewed:**

**Health Care Agent:**

**Living Will:**

☐ Yes  ☐ No  **Date:**

**Location:**

**Reviewed:**

**Cancelled (Date):**

**Durable Medical Power of Attorney:**

☐ Yes  ☐ No  **Date:**

**Location:**

**Reviewed:**

**Cancelled (Date):**

**Oral Directives:**

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201 Lower Notch Rd. Suite B1 Little Falls NJ 07424 Ph: 877-920-2090 Fax: 877-920-0466
PLEASE READ IMMEDIATELY

NURSES: Please remove labels from all Immune Globulin bottles infused, placing them on the "Patient IV Documentation Flow Sheet"

Enclosed is the new-patient start packet. Please complete all documents and return to HomeCare Rx:

Patient Consent Forms:
  o Release of Information & Consent of treatment
  o Patient's rights and responsibilities
  o Privacy Notice
  o Advance Directives
  o Emergency Kardex
  o Assignment of Benefits (AOB)

Nursing:
  o Nursing Notes (Pages 1 & 2)
  o Patient/Caregiver Instructional Checklist
  o Medication Profile
  o Initial History & Physical Pages (1 & 2)
  o Plan of Care (pages 1-3)
HomeCare Rx, Inc. is required to maintain the confidentiality of your Healthcare information. The following notice describes how your medical information may be used and disclosed by HomeCare Rx as well as your rights regarding access to this information. Please review this notice carefully.

Your confidential healthcare information may be released:

✓ To healthcare professionals within our organization for the purposes of providing you with quality home care
✓ To Physicians, healthcare agencies and pharmaceutical providers who are directly involved with your care
✓ To your insurance provider for the purpose of receiving payment for the healthcare services provided to you
✓ To other healthcare providers in the event that you need emergency care
✓ To Public or Law enforcement officials in the event of an investigation of a crime in which you are a victim

Your confidential healthcare information MAY NOT be released for any other purpose than that which is identified in this notice. Your confidential healthcare information may be released to individuals or entities not set forth in this notice only after receiving written permission from you. You also have the right to revoke this permission to release confidential healthcare information at any time.

You have certain rights regarding your confidential healthcare information which include:

✓ The right to restrict the use of your confidential healthcare information. However, HomeCare Rx may refuse your restriction if it is in conflict with applicable federal or state laws, the delivery of quality healthcare or in the event of an emergency situation.
✓ The right to receive confidential communication about your health status
✓ The right to review and photocopy and/or portions of your healthcare information
✓ The right to make changes to your healthcare information.
✓ The right to request an accounting of the uses and disclosure of your confidential healthcare information for a period of six years prior to your request. This accounting applies to disclosures to individuals or business associates other than for the purposes of treatment, payment and healthcare options.
✓ The right to receive information regarding HomeCare Rx, Inc. duties, use and disclosure practices associated with confidential healthcare information
✓ The right to receive a copy of this Privacy Notice upon request, which can be in electronic or paper form

You have the right to further information regarding this Privacy Notice, as well as the right to complain to our facility if you believe your rights to privacy have been violated. All complaints to our facility will be investigated and held confidential without fear of reprisal. For further information and/or to submit a complaint you may contact the individual named below by telephone or by mailing your inquiry and or complaint to:

Ami Patel, Rph
HomeCare Rx
201 Lower Notch Rd. Suite B1
Little Falls NJ 07424
877-920-2090

This notice is effective March 1, 2015. If the patient lacks the capacity to sign this service agreement, this agreement may be signed by an individual or entity legally authorized to represent the patient.

Signature or Patient or Legal Representative ___________________________ Date ______________

201 Lower Notch Rd. Suite B1 Little Falls NJ 07494 Ph: 877-920-2090 Fax: 877-920-0466
PT. INFORMATION RELEASE-TREATMENT CONSENT

1. PATIENT SELF DETERMINATION ACT & BILL OF RIGHTS
I have received a written statement of my rights as a patient of the Provider. I understand my rights because they have been explained to me and my questions have been answered. I have received verbal information about advance directives, company policy, applicable state law, my rights under state law, and other information necessary to make decisions about advance directives and my care in accordance with the Patient Self Determination Act of 1990.

2. RELEASE OF INFORMATION
I consent to release of Information by my Physician, Licensed Health Care Professionals, or Facility and to allow the disclosure of medical records kept by the above Provider. I consent to the release of information by the Provider or their representatives to representatives of other health care providers involved in my care and other third party payers in order to insure continuity of treatment, proper communication of information to my physician(s) and referral source, and proper reimbursement of services.

3. CONSENT FOR TREATMENT
I voluntarily consent to receive treatment from the Provider consistent with a medical treatment plan authorized by my physician. I understand that if I am in such condition as to need services not provided by Provider, such services must be arranged by me or my legal representatives, or my physician. The Provider shall assist in locating such services, but shall in no way be responsible for failure to provide the same, and is hereby released from any and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood or bodily fluids, I give permission for my blood to be tested for infectious diseases such as HIV or Hepatitis. I understand that the exposed employee will be informed of the results of the test. I understand that I will be billed for any lab fees incurred should the employee sustain any exposure.

4. CONSENT FOR INFUSION SERVICES
My physician has informed me of the potential risk associated with this therapy. The specifics of therapy, namely why the therapy is used, what specific agents have been prescribed, how these agents will be administered, and my role in providing the therapy have all been discussed with me prior to the initiation of the therapy. All questions regarding my care have been answered to my satisfaction. Therefore, I consent to the administration of home infusion therapy. I understand my care will be under the supervision of a registered nurse and my physician.

Signature of Patient or Legal Guardian ____________________________ Date __________

Provider ____________________________ Date __________
Witness ____________________________ Date __________

201 Lower Notch Rd. Suite B1 Little Falls NJ 07424 Phone: 877-920-2090 Fax: 877-920-0466
If you are directed to evacuate from your home due to an emergency situation bring this form along with your emergency supplies. This form contains important medical information and will assist the emergency management volunteers to direct you to appropriate services. KEEP THIS FORM IN A SAFE AND ACCESSIBLE LOCATION.

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<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<td>Address:</td>
<td>City/Town/Village:</td>
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<td>Telephone:</td>
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<td>#1 Emergency contact (Local):</td>
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<td>#2 Emergency contact</td>
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<td>Physician:</td>
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<td>Pharmacy:</td>
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<td>Medical Supplier/Oxygen Provider:</td>
<td>Telephone#</td>
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<td>Medical History:</td>
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</table>

Medications: Self-Administered □ Yes □ No, identify individual responsible
List all medications:

Advance Directives: □ Yes (Attach copy) □ No Proxy:
DNR □ Yes (Attach copy) □ No

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<thead>
<tr>
<th>Allergies:</th>
<th>Diet Needs:</th>
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<tr>
<td>Mental Status:</td>
<td>Community Agencies Involved:</td>
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<tr>
<td>Daily care required:</td>
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Please put together an emergency bag that contains the following: Bedding, Blanket, Snacks, Water, Medication list, Medical supplies, Personal care items i.e. comb/brush, Toothbrush/paste, clothing, equipment i.e. walker, wheelchair and personal identification and health insurance ID card. Remember to take your medications with you.
# Patient/Caregiver Instructional Checklist

<table>
<thead>
<tr>
<th>Topic (check all that apply)</th>
<th>Instruction Date</th>
<th>Init.</th>
<th>Demo Date</th>
<th>Init.</th>
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<tbody>
<tr>
<td>1. Introduction to InfuCare services</td>
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<td>- Patient rights and responsibilities</td>
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<td>- 24hr on-call RNs and RPHs</td>
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<td>2. General Therapy Information</td>
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<td>- Reason for therapy</td>
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<td>- Side effects discussed</td>
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<td>- Medication Sheet given</td>
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<td>- Self Monitoring</td>
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<td>- Pump instruction w/ Written Info</td>
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<td>- Trouble Shooting Brand</td>
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<td>- How to Keep Pump Clean</td>
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<td>- Pre Meds for Side effects</td>
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<td>3. Aseptic Techniques</td>
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<td>- Universal Precautions</td>
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<td>- General Procedures</td>
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<td>- Handwashing</td>
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<td>4. Treatment Administration</td>
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<td>- Preparation of Syringe</td>
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<td>- Tubing Changes</td>
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<td>- Needle/Cannula Changes</td>
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<td>- Direct Connection</td>
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<td>- Start/Stop Infusion</td>
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<td>- Heparin/Saline Flush</td>
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<td>5. Catheter Care</td>
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<td>- Dressing Change</td>
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<td>- Per Protocol Sterile</td>
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<td>- Variation</td>
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<td>- Injection Cap Change</td>
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<td>- Routine Flushing</td>
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<td>- Lab Draw by PT/CG</td>
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<td>6. Catheter Complications</td>
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<td>- Phlebitis</td>
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<td>7. Chemo Precautions</td>
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<td>- Protective Gear</td>
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<td>- PT/CG Acknowledge Responsibility for Safe Home</td>
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<td>- Sharps Container Use</td>
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The above information has been reviewed in a language and methods that I understand. It is my responsibility to carry out procedures and skills as instructed. I understand that the durable equipment required for my therapy is the property of InfuCare RX, Inc. and is to be returned.

Patient/Caregiver Signature: ____________________________  Relation: ____________________________  Date: ____________________________

Instructor/Sig: ____________________________  Date: ____________________________  Instructor Sig: ____________________________  Date: ____________________________
MEDICATION PROFILE

Patient Name: ________________________________  Physician: ________________________________

Allergies: ________________________________  Phone: ________________________________

DIAGNOSIS: ________________________________

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</table>

***PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDS, HOME REMEDIES, AND INVESTIGATIONAL AGENTS.

***PLEASE INCLUDE ALL HPC THERAPIES

RN SIGNATURE: ________________________________  DATE: ________________________________

MD SIGNATURE: ________________________________  DATE: ________________________________
**HISTORY AND PHYSICAL ASSESSMENT**

### PATIENT DEMOGRAPHIC

<table>
<thead>
<tr>
<th>Name</th>
<th>Account#</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td>Age</td>
<td>Ht</td>
</tr>
<tr>
<td>Primary Dr</td>
<td>Secondary Dr</td>
<td></td>
</tr>
<tr>
<td>Therapy: Enter Drug Solution, Dose, Route, Freq</td>
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</tr>
</tbody>
</table>

### MEDICAL/SURGICAL HISTORY

- Check all that apply within description:
  - Chemical Dependency
  - Neuro
  - Head/Neck
  - EENT
  - Glasses: Yes | No
  - Endocrine
  - Skin
  - Immune
  - Musculoskeletal
  - Recent Immunizations
  - Hx of Present Illness
  - Other:
  - Surgeries (Enter Surgeries and Dates) No Surgeries

### THERAPY ACCESS

- Vein Status: Good | Fair | Poor | N/A
- Access Device | Brand | #Lumen
- Length | Gauge | Exposed Cath Length
- Location | Tunneled? | Insert Date
- Inserted By | CVC Tip Location
- Comments:

### REVIEW OF SYSTEMS

#### Head and Neck

- WNL | Masses | Deformity | Alopecia
- Circ | Other
- Eyes
  - WNL | Blood | Discharge | Itching
  - Jaundice | Redness | Tearing
  - Other
- Nose
  - WNL | Congestion | Discharge | Epistaxis
  - Other

#### Mouth & Throat

- WNL | Full Dentures | Partial Dentures
- Lesions | Thrush/Candidiasis | Inflamed
- Dysphagia/Aphagia | Other

#### Skin

- WNL | Pain | Cyanotic | Flushed | Warm | Cool
- Bruises | Rash | Dry | Tenting | Lesions
- Mottled | Petechial | Jaundiced | Incisions
- Wounds
  - Desquamation
  - Decubitus
  - Stomas
  - Colostomy
  - Ileostomy
  - Conduit
  - Other:

---

[Diagram of human body: Right | Left | Left | Right]
### Neurological
- WNL
- Headache
- Disoriented
- Forgetful
- Memory Loss
- Paresis
- Paresthesia
- Numbness
- Paralysis
- Hemiplegic
- Paraplegic
- Spasms
- Tremors
- Seizures
- Dizziness
- Vertigo
- Gait Problems
- Impaired Speech
- Unresponsive
- Other

### Musculoskeletal
- WNL
- Amputation
- Atrophy
- Contractures
- Spinal Problems
- Joints: Tenderness
- Swelling
- Decreased ROM
- Assistive Devices
- Other

### Endocrine
- WNL
- Diabetes
- Other

### Cardiovascular
- WNL
- Irregular Pulse
- Tachy
- Brady
- Murmurs
- Palpitations
- Chest Pain
- SOB
- Extra Sounds
- Distended Neck Veins
- Hypotensive
- Hypertensive
- EDEMA: 1+ 2+ 3+ Non-Pitting Location
- Peripheral Pulses: (0, 1+, 2+, 3+, 4+)
- Rt Radial
- Lt Radial
- Rt Pedal
- Lt Pedal
- Other

### Gastrointestinal
- WNL
- Nausea
- Vomiting
- Diarrhea
- Blood
- Constipation
- Cramping
- Heartburn
- Stoma
- Bowel Sounds: Active
- Hypo
- Hyper
- Absent
- Abdomen: Soft
- Distended
- Tight
- Tender
- Other

### Reproductive
- WNL
- Dysmenorrhea
- Amenorrhea
- Menopause
- Post-Menopausal
- Gravid
- Para
- Pregnant: Gestation Week
- Postpartum
- Discharge
- Impotence
- Other

### Genitourinary
- WNL
- Frequency
- Urgency
- Burning
- Pain
- Incontinence: Catheter
- Incontinence Product
- Urine: Cloudy
- Bloody
- Sediment
- Color
- Genitalia: Discharge
- Inflamed
- Lesions
- Masses
- Breasts: Asymmetrical
- Lumps/Nodes
- Tender
- Discharge
- Lumpectomy
- Mastectomy
- Other

### Pain Assessment
- No Pain
- Location: ______________
- Continuous
- Intermittent
- Quality
- Intensity (1-10)
- Exacerbated by __________________________
- Alleviated by __________________________

### Psychological
- WNL
- Anxious
- Depressed
- Angry
- Mood Swings
- Sleep Problems
- Withdrawn
- Developmental Needs: __________________________
- Support Systems: __________________________
- Advanced Directives: In Place
- Not Executed
- Discussed
- Resuscitation: Yes
- No
- DNR Order: Yes
- No

### Environment
- Residence
- Condition: Clean
- Unclean
- Cluttered
- Pets
- Adeq. Storage
- Adeq. Workspace
- Utilities: Clean water
- Electricity
- Heat
- Telephone
- Refrigerator
- Hazards Checked & Discussed: Fire
- Electrical
- Falls
- Poisons
- Severe Weather
- Evacuation
- BR Safety
- Recommendations: Safe Home: Yes
- No
- NA
- Overall Candidacy for Home Care: Good
- Fair
- Poor
- Need for other services: __________________________

### Narrative (SOAP Preferred)

---

### Next Scheduled Visit: __________________________

---

**Signature:** __________________________

**License #:** __________________________

**Date:** __________________________
<table>
<thead>
<tr>
<th>No.</th>
<th>NURSING EXPECTED OUTCOMES</th>
<th>ACTIVE DATE</th>
<th>INIT.</th>
<th>ACTON PLAN</th>
<th>MODIFICATION REVIEW</th>
<th>DATE</th>
<th>INIT.</th>
<th>RESOLVE DATE</th>
<th>INIT.</th>
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</table>
| 1.  | Deficit in knowledge of health maintenance resources                |             |       | a.) HomeCare Rx representatives will inform Pt/CG of their rights and responsibilities  
    b.) HomeCare Rx will introduce the company and services offered and method of supply/delivery  
    c.) Pt/CG will be informed of RN and Rph availability  
    24hrs/day 7days/week.  
    d.) Have the Pt/CG sign the agreement for services which includes financial arrangements  
    e.) Pt/CG will indicate acceptance of the care responsibilities by signing the teaching checklists  
    f.) HomeCare Rx will coordinate and discuss “Advance Directives” leaving a brochure in the home  
    g.) HomeCare Rx will coordinate infusion care with other homecare agencies when necessary  
    h.) Nursing Care to be done by ___________________ agency |             |       |                                                                            |                     |      |       |              |       |
| 2.  | Altered                                                            |             |       |                                                                            |                     |      |       |              |       |
|     | R/T                                                                 |             |       |                                                                            |                     |      |       |              |       |
|     | Pt/CG will                                                          |             |       |                                                                            |                     |      |       |              |       |
|     |                                                                    |             |       |                                                                            |                     |      |       |              |       |
| 3.  | Knowledge deficit R/T home therapy. Pt/CG will be independent in the sale administration of the system |             |       |                                                                            |                     |      |       |              |       |
|     |                                                                    |             |       |                                                                            |                     |      |       |              |       |

RN Sig. __________________ Date Init. __________________
RN Sig. __________________ Date Init. ________________
RN Sig. __________________ Date Init. ________________
RN Sig. __________________ Date Init. ________________
RN Sig. __________________ Date Init. ________________
RN Sig. __________________ Date Init. ________________
## PLAN OF CARE FOR HOME

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<tr>
<td>3.</td>
<td>(CONTINUED)</td>
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<td>d.) Instruct Pt/CG on troubleshooting the administration system: ALARMS AIFLOCKS LEAKS CRIMPED TUBING ELECTRIC SOURCE BREAKAGE</td>
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<td>Knowledge deficit about aseptic technique. Pt/CG will maintain good aseptic technique during procedures and experience no contamination</td>
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<td></td>
<td>e.) HomeCare Rx to monitor for drug interactions via med. profile. f.) RN to do all therapy</td>
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<td></td>
<td>a.) Provide written instructions that outline aseptic techniques b.) Demonstrate with a return demonstration, aseptic technique: Hand washing Aseptic use Do not touch sterile tips Donning gloves Clean work space Wearing a mask</td>
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<td>5.</td>
<td>Altered Skin/Vascular Integrity R/T medication access device. Pt/CG will have no therapy interruption due to access device complication</td>
<td></td>
<td></td>
<td>a.) Inform Pt/CG about type of device: CVC Periph PICC Midline Port SubQ device. b.) Instruct Pt/CG to monitor for signs and symptoms of phlebitis and infection. Temp Redness Tenderness Swelling Drainage Cord Formation Increased Vasculature c.) Instruct Pt/CG to access device dressing change Sterile every d.) RN to do dressing changes e.) instruct Pt/CG to flush access device with NS ccs Heparin U/ml ccs f.) Pt/CG to change injection cap every g.) RN to do Injection Cap Change</td>
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<tr>
<td>6.</td>
<td>Knowledge deficit regarding universal precautions</td>
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<td>Instruct the Pt/CG to: A.) Avoid contact with bodily secretions and blood B.) Not to recap needles Safely recap needles C.) Use needleless systems D.) Dispose of all sharps and medical waste properly E.) Clean equipment supplies and lines as indicated F.) Wear gloves gowns when indicated g.) Notify MD and HomeCare RX should exposure occur</td>
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</tr>
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</table>

<p>| RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. | RN Sig. | Date | Init. |</p>
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| 7.  | Potential for ineffective coping with illness and/or illness outcomes within his/her cultural perspective. Pt/CG will use effective resources to make informed care disclosures |             |       | a.) Encourage verbalization of illness/care concerns between home members and healthcare team  
b.) Emphasize use of appropriate support groups i.e hospice, Oley, AIDS and Lyme organizations and cultural centers and groups  
c.) Arrange for interpretive services as needed  
d.) Encourage appropriate spiritual/emotional counseling  
e.) Encourage development of temporary alternative | | | | |
| 8.  | Potential for altered protection R/T physical and/or emotional risks Pt/CG will maintain safe home environment and take appropriate precautions should risks arise |             |       | a.) Present home safety information to the Pt/CG. Leave info in the home as a reference  
b.) R.N. to check for obvious safety hazards in the home  
c.) R.N. to correct if possible, or recommend correction of obvious hazards  
d.) Referral to appropriate resources should home be grossly unsafe (fire dept., public health dept., state hot lines)  
e.) Review emergency plans for continuation of services during inclement weather  
f.) Encourage Pt/CG to perform safety check of household using home safety information as a guide | | | | |
| 9.  | Pt’s nutritional risk of: Zero__  
Low__  
Mod__  
High___ resulting in possible altered nutritional requirements Pt’s nutritional status will stabilize or improve Pt will follow __________ diet throughout therapy or until order for change | |       | a.) Encourage adherence to any prescribed diet utilizing cultural food preferences when possible  
b.) Offer dietary information or refer patient to culturally knowledgeable nutritionist/dietician for education/counseling  
c.) Encourage adherence to supplements, TPN or Enteral regimen. (Refer to previous therapy problem in Care Plan).  
d.) Supplements/snacks  
e.) Pt to be NPO  
f.) Encourage adequate fluid intake | | | | |
| 10. | Need for early discharge planning Pt/CG will be Included in and agree with plans for discharge | |       | a.) Expected discharge date:  
b.) No expected discharge date due to:  
c.) Pt will be discharged to Self-care __________ Caregiver__________  
d.) Refer or transfer to __________ for continued service or follow up in the areas | | | | |