

Patient Name:

DOB:

BAMLANIVIMAB INFUSION FLOWSHEET

Date of Service:	Supervising Provider:
Place of Service:	
Check to indicate the following requirements have been met:	
<input type="checkbox"/> Patient ID confirmed	<input type="checkbox"/> Valid order received
<input type="checkbox"/> Check-in forms completed	
<input type="checkbox"/> Patient/Caregiver has received and reviewed Fact Sheet for Patients and Parents/Caregivers	

Pre-Infusion Assessment

Is patient experiencing any of the following emergency warning signs?
 If yes, initiate supportive treatment as appropriate (e.g. supplemental oxygen) and notify supervising provider and/or activate emergency response system per facility protocol.

Chest pain/pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lethargy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Oxygen sat less than 94% on RA	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tachypnea (RR > 30)	<input type="checkbox"/> No <input type="checkbox"/> Yes
New-onset confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cyanosis	<input type="checkbox"/> No <input type="checkbox"/> Yes

Baseline Vital Signs

Time	BP (mmHg)	HR (bpm)	RR (per min)	O2 sat (%)	Temp (°F)	Staff initials

Vascular Access (document *all* attempts; use Additional Notes/Orders page if needed)

Device	Gauge	Laterality	Site	Staff Initials
peripheral <input type="checkbox"/> IV	<input type="checkbox"/> #24 <input type="checkbox"/> #22	<input type="checkbox"/> left	<input type="checkbox"/> forearm <input type="checkbox"/> AC <input type="checkbox"/> hand	
	<input type="checkbox"/> #20 <input type="checkbox"/> other:	<input type="checkbox"/> right	<input type="checkbox"/> other:	
peripheral <input type="checkbox"/> IV	<input type="checkbox"/> #24 <input type="checkbox"/> #22	<input type="checkbox"/> left	<input type="checkbox"/> forearm <input type="checkbox"/> AC <input type="checkbox"/> hand	
	<input type="checkbox"/> #20 <input type="checkbox"/> other:	<input type="checkbox"/> right	<input type="checkbox"/> other:	
Flushes easily? <input type="checkbox"/> Yes <input type="checkbox"/> No, see notes Blood return present? <input type="checkbox"/> Yes <input type="checkbox"/> No, see notes			Patient response to procedure <input type="checkbox"/> Tolerated well <input type="checkbox"/> Other, see notes	

Notes:

Medication Preparation

Drug/Diluent	Dose/Volume	Lot Number	Exp. Date

Time Prepared:	Staff initials:
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Medication Administration								
0.2/0.22-micron filter used? <input type="checkbox"/> Yes (required)								
Task	Time	Rate (ml/hr)	BP (mmHg)	HR (bpm)	RR (per min)	O2 sat (%)	Temp (°F)	Staff Initials
Infusion started								
15 min VS check								
VS check (PRN)								
VS check (PRN)								
VS check (PRN)								
Infusion complete								
Notes:								
60-Minute Observation Period								
Notes:							Arrival time in observation area (if applicable):	
							Staff initials:	
Discharge								
Departure vitals	BP (mmHg)	HR (bpm)	RR (per min)	O2 sat (%)	Temp (°F)	Patient condition at discharge:		
Time:						<input type="checkbox"/> Stable <input type="checkbox"/> Unstable, see notes		
IV Removal	Site condition:		Dressing Applied		Patient response to procedure			
Tip intact? <input type="checkbox"/> Yes <input type="checkbox"/> No, see notes	<input type="checkbox"/> benign <input type="checkbox"/> swelling <input type="checkbox"/> warmth <input type="checkbox"/> drainage <input type="checkbox"/> bruising <input type="checkbox"/> redness <input type="checkbox"/> other, see notes		<input type="checkbox"/> gauze and tape <input type="checkbox"/> adhesive bandage <input type="checkbox"/> other, see notes		<input type="checkbox"/> Tolerated well <input type="checkbox"/> Other, see notes Infiltration? <input type="checkbox"/> No <input type="checkbox"/> Yes, see notes Phlebitis? <input type="checkbox"/> No <input type="checkbox"/> Yes, see notes			
Discharge Education Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No, see notes								
Disposition: <input type="checkbox"/> Home <input type="checkbox"/> Other (e.g. long term care facility):								
Records Faxed to Prescriber? <input type="checkbox"/> Yes <input type="checkbox"/> No, see notes						Staff initials:		

