

VITALITY MOBILE IV THERAPY

Infusion and Injection Procedure Record Form

Patient Name: _____ Date: _____

Infusion Type: _____ Injection Type: _____

Baseline VS: BP _____ O2 _____ HR _____ RR _____

Injection Dose and Site of Injection:

Infusion Dose and Site/Type of IV:

IV Push Dose and Time:

Infusion Start Time: _____ Infusion End Time: _____

Post-Infusion/Injection Vitals: BP _____ O2 _____ HR _____ RR _____

Patient Tolerated Infusion _____ (initials of infusing clinician go here)

Patient ambulatory, alert, and well post infusion/injection _____

Peripheral IV was discontinued and dressing applied _____

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Injection site dressing applied _____

Discharge paperwork reviewed and provided to patient _____

Additional notes:

RN/LPN/EMT

Signature: _____ Date: _____

Medical Provider (Sign off if RN/LPN/EMT operating off standing order)

Signature: _____ Date: _____