



Infusion Services

**Pharmacy Care Plan:**

Name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Primary Care Giver \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Access \_\_\_\_\_  
 Date Placed     /   /  
 Func. Limitations \_\_\_\_\_

Primary MD \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Primary RN \_\_\_\_\_  
 HT/WT \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Ordered Therapies \_\_\_\_\_

Is the ordered drug, dose/ route/ Freq. Appropriate?     Yes or No  
 Are there drug duplications in the regimen?             Yes or No  
 Are the lab tests / clinical monitoring appropriate?     Yes or No

Admission Note:

**PROBLEMS / GOALS / INTERVENTIONS**

**Problems:**

Date ID'd	Description	Resolved	Date
	Potential for equipment malfunction		
	Potential for allergic or adverse rxns. to drug		

**Goals:**

Date ID'd	Description	Met	Date
	Patient will not develop rash, fever, or allergic rxn		
	Patient's blood pressure to remain stable		
	Patient will not develop peripheral edema		
	Patient's weight to remain stable		
	Pump will operate with no problems		

**Interventions:**

Date ID'd	Description	Date DC'd
	Monitor for s/s of rash, fever, allergic rxn	
	Monitor for changes in blood pressure	
	Monitor for s/s of peripheral edema	
	Monitor for changes in patient's weight	
	Monitor for catheter complications & report to MD if needed	

R.N.'s Name \_\_\_\_\_

RPh's Name \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_