



Febrile Neutropenic Clinic Follow-Up Assessment

ADDRESOGRAPH

	Date/Time:	Date/Time:	Date/Time:
Follow-up Visit Number:			
Lab Parameters Reviewed: CBC – ANC - Platelets	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Creatinine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Cultures	<input type="checkbox"/> Yes <input type="checkbox"/> No Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No Site:
Urine C&S	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assessment: 1. Vital Signs	BP: Temp: Resp. Rate: Heart Rate:	BP: Temp: Resp. Rate: Heart Rate:	BP: Temp: Resp Rate: Heart Rate:
2. Have you had a higher fever since last seen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have new or worse mouth sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have new or worse diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have new or worse abdominal pain or cramping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have burning upon voiding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have any new chest pain, cough, SOB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is there evidence of thrush or stomatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No Grade: 0 1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No Grade: 0 1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No Grade: 0 1 2 3 4
9. Is the VAD(s) free from visible infection? (redness, swelling, purulent discharge).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plan of Care: 1. Refer to M.D. (Refer to M.D. as per follow-up protocol or concerns on part of nurse)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Return to Clinic appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:
3. Telephone follow-up by R.N. required.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:
Notification: 1. Assessment photocopied and given to patient.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Charge Nurse notified and assessment faxed to K.G.H. Emergency Department.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:
Signature/Designation:			
Print Name/Designation:			

FOR ADDITION FINDINGS USE BACK OF PAGE

