CVC Active Surveillance Individual Patient Tracking Form

Patient Name / ID# ________________________________________________ SOC ____________

Month/Quarter/Year ____________________________________________

IV Site        Oral       Gastrointestinal       Blood

[ ] Peripheral*  [ ] Central (includes PICC & Port) Specify:

DX: ____________________________________________________________________ Last ACF/ECF: _________

Primary Nurse: _______________________________________________ Institution: ______________

Device Days:

(Counting days on service with pt. in home and device in place; any portion of day = 1 day)

Date in: _______________ to Date (out): _______________  # of Days: _______________
Date in: _______________ to Date (out): _______________  # of Days: _______________
Date in: _______________ to Date (out): _______________  # of Days: _______________

Total Device Days: __________

Number of infections: ______

Signs & Symptoms Observed Related to Presence of an Infection: (Check box and/or describe)

Date first observed:

☐ Elevated WBC  ☐ Increased Urine Sediment/Cloudy Urine  ☐ Wound Pain
☐ Fever/chills (T 100.4)  ☐ Hematuria  ☐ Purulent Drainage
☐ Mental Status Changes  ☐ Malodorous Urine  ☐ Increased Amount of Wound Drainage
☐ IV Site Purulent Drainage  ☐ Dysuria/Flank Pain  ☐ Cough
☐ CVC/IV Site Pain  ☐ Dyspnea  ☐ Change in Sputum Color
☐ IV Site Erythema  ☐ Erythema  ☐ Other: ________________________________

Explaination/Description: __________________________________________________________________

Source of suspected infection (if known): ______________________________________________________

Factors associated with development of infection: ____________________________________________

Has the Physician been notified of above observations?  ☐ Yes  ☐ No

If yes, name of MD who was notified: ________________________________________ Phone: ___________________
Date notified: __________________________________________ Time: _____________________

Orders Received

Lab Orders: __________________________________________ Date/Time Started: ________________

Medications Ordered: _________________________________________ Date/Time Started: ________________

Order to DC central venous catheter due to suspected infection?  ☐ Yes  ☐ No

Other: __________________________________________________________________________________

Results/Findings:  Resolution Date: __________

Pathogens Identified: __________________________________________________________________________

*New Diagnosis:  ☐ Yes  ☐ No  If yes, state: ________________________________

Follow-up Required/Additional Comments: __________________________________________________________________________

*Is the infection communicable and reportable?  ☐ Yes  ☐ No  If yes, report to your clinical supervisor within 24 hours.

Reported by: (name) ______________________________________ Date: _______________ Time: __________

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