



PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Date: _____

IV INFILTRATIONS

Patient's Name: _____ MRN: _____

Inpatient, Outpatient, or Emergency Room Patient (circle one)

Type of Exam - _____ Patient's age - _____

Location of IV site – Right / Left _____

Size of IV catheter used - 14g 16g 18g 20g 22g

Flow rate - _____ ml/sec Who started IV - _____

IV flushed before being connected to injector – Yes / No

IV site monitored at the beginning of the injection – Yes / No

Who monitored IV site? - _____

Was the injection stopped because infiltration was witnessed? – Yes / No

Was dual injection (saline/contrast) used?— Yes / No

What was infiltrated? – Saline / Contrast / Both

What was the time of the infiltration? - _____ AM / PM

Estimated amount infiltrated - _____

How long ago (how old) was the IV started? - _____

Quality Report Number? _____

Nurse Notified: _____

Physician notified: _____

Additional Comments - _____

Send this form to the RADHU. (The rest of this form is completed by Radiology Nursing)

Patient given appropriate instructions upon release – Yes / No

Follow up call place by _____ on _____ and the patient's condition is _____

Interpreter's signature: _____ Date: _____