IV THERAPY CHECKLIST

NAME :
DATE OF BIRTH : SEX :
ADMIT DATE : ROOM NO.:
MRN : EPISODE NO.:

Type of Cannulation : Peripheral Line / Central Line / Chemoport / Arterial Line / Umbilical Artery Catheter / Umbilical Vein Catheter

Date of Insertion : _____

Site of Insertion : _____

Inserted by : _____

Date of Removal : _____

Removed by : _____

Legend

YES (✓) NO (X)

DATE	TIME	PAIN	SWELLING	REDNESS	DISCHARGE FROM IV SITE	LEAKING	FLUSHING	BACK FLOW	DRESSING CHANGED	TUBING CHANGED	REMARKS	CHECKED BY

N-13/10/05-167-1

	DATE
	TIME
	PAIN
	SWELLING
	REDNESS
	DISCHARGE FROM IV SITE
	LEAKING
	FLUSHING
	BACK FLOW
	DRESSING CHANGED
	TUBING CHANGED
	REMARKS
	CHECKED BY