Appendix E: Low Risk Febrile Neutropenia Home observation chart

Low-risk FN program – Home observation chart
Version 3. Date: 30.03.2020

HOSPITAL LOGO

Low-risk febrile neutropenia

Assessment form

Write patient details or affix patient label
Surname ....
Given names ....
Unit number ....
Date of birth ....

Home observation and assessment chart: to be completed by patient and CNS						
Intervention /assessment		**Day 1** **Date**	**Day 2** **Date**	**Day 3** **Date**	**Day 4** **Date**	**Day 5** **Date** ....
Patient/carer to complete						
Temperature: Recorded 4-6 hourly during waking hours		1. Time.......... Temp......... 2. Time.......... Temp......... 3. Time.......... Temp......... 4. Time.......... Temp......... 5. Time.......... Temp......... 6. Time.......... Temp.........	1. Time.......... Temp......... 2. Time.......... Temp......... 3. Time.......... Temp......... 4. Time.......... Temp......... 5. Time.......... Temp......... 6. Time.......... Temp.........	1. Time.......... Temp......... 2. Time.......... Temp......... 3. Time.......... Temp......... 4. Time.......... Temp......... 5. Time.......... Temp......... 6. Time.......... Temp.........	1. Time.......... Temp......... 2. Time.......... Temp......... 3. Time.......... Temp......... 4. Time.......... Temp......... 5. Time.......... Temp......... 6. Time.......... Temp.........	1. Time.......... Temp......... 2. Time.......... Temp......... 3. Time.......... Temp......... 4. Time.......... Temp......... 5. Time.......... Temp......... 6. Time.......... Temp.........
CNS to complete						
Blood culture results						

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CNS nurse to complete	Day 1		Day 2		Day 3		Day 4		Day 5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is Patient alert and orientated	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Any overnight chills or shakes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tolerating normal diet without vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Any reported concerns over dehydration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Is child passing normal amounts of urine in the last 24 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Normal bowel patterns with no diarrhoea over previous 24 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient & carer understand reasons to trigger contact with hospital personnel	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CNS nurse signature	.....		.....		.....		.....		.....	

Document any issues identified (these must be discussed with CNS nurse co-ordinator and/or treating team)