Online Supplement Appendix A. PICC Appropriateness Assessment Form*

RN NAME:________________________ PHONE#_____________________ ROOM #_______________________

Date Consult Received: _________________Time:________________ Insertion Date/Time:_____________________

REASON FOR INSERTION:

NUTRITION: ________ TPN TYPE/DOSE ______________________________***FINAL DOSE FOR PICC MUST HAVE OSMOLARITY=>900**

ABX/MED :__________ NAME OF MED:____________________________ HOW LONG WILL PT RECEIVE_______________

APPROPRIATE ROUTE FOR ADMINSTRATION PER IV GUIDELINES: _______PERIPHERAL/MIDLINE _______PICC/CENTRAL LINE

*PICC not appropriate for therapy<14days when it can be administered through peripheral/midline.

HAS ID CONFIRMED ORDER FOR HOME ABX THERAPY Y / N INSURANCE AUTH COMPLETED FOR HOME THERAPY Y / N

MULTIPLE INCOMPATIBLE MEDS: ________ LIST MEDICATIONS:____

DIFFICULT ACCESS:________ HAVE 2 IV NURSES ATTEMPTED PIV INSERTION WITH ULTRASOUND: YES NO

*****IF YES THEN MIDLINE IS PREFERRED NEXT STEP**

BLOOD DRAW FREQUENCY: HAVE 2 PHLEB ATTEMPTED LAB DRAW: Y / N

*Form filled by vascular access nurse at the time of PICC order to review appropriateness. If PICC deemed inappropriate (based on indication, proposed duration of treatment or infusion type), alternative vascular access device suggested.