### Online Supplement Appendix A. PICC Appropriateness Assessment Form*

<table>
<thead>
<tr>
<th>RN NAME:</th>
<th>PHONE#</th>
<th>ROOM #</th>
</tr>
</thead>
</table>

Date Consult Received: __________ Time: __________ Insertion Date/Time: __________

**REASON FOR INSERTION:**

<table>
<thead>
<tr>
<th>NUTRITION:</th>
<th>TPN TYPE/DOSE</th>
<th>*FINAL Dose FOR PICC MUST HAVE OSMOLARITY $&gt;_{900}$</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ABX/MED:</th>
<th>NAME OF MED:</th>
<th>HOW LONG WILL PT RECEIVE</th>
</tr>
</thead>
</table>

**APPROPRIATE ROUTE FOR ADMINISTRATION PER IV GUIDELINES:**

- **PERIPHERAL/MIDLINE**
- **PICC/CENTRAL LINE**

*PICC not appropriate for therapy $<_{14}$ days 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

**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.*