

Heart Failure Infusion Services Enrollment/Order Form

Referral Date:

Patient Information		
Patient Name:	Patient Phone:	DOB:
Address:	City, State:	Zip:
Caregiver Name:	Relationship:	Phone:
Please Include: <input type="checkbox"/> Demographics <input type="checkbox"/> Insurance Info <input type="checkbox"/> History & Physical <input type="checkbox"/> Medication List <input type="checkbox"/> Progress Notes		
Therapy Start Date:	Hospital & Room #:	

Clinical Background		
Primary Diagnosis: <input type="checkbox"/> Heart Failure <input type="checkbox"/> Other:		
Allergies: <input type="checkbox"/> NKDA	DNR status: <input type="checkbox"/> Order Received <input type="checkbox"/> N/A	
Ht: <input type="checkbox"/> in <input type="checkbox"/> cm	Wt: <input type="checkbox"/> lb <input type="checkbox"/> kg	
Plan of Care: <input type="checkbox"/> Bridge to Transplant <input type="checkbox"/> Bridge to VAD <input type="checkbox"/> Bridge to Decision <input type="checkbox"/> Palliative		

Prescription and Orders		
<input type="checkbox"/> Milrinone	Administer _____ mcg/kg/min	<input type="checkbox"/> Continuously via ambulatory infusion pump
<input type="checkbox"/> Dobutamine	Administer _____ mcg/kg/min	<input type="checkbox"/> Continuously via ambulatory infusion pump
<input type="checkbox"/> Dopamine	Administer _____ mcg/kg/min	<input type="checkbox"/> Continuously via ambulatory infusion pump
Dosing weight: (if different than actual wt): <input type="checkbox"/> lb <input type="checkbox"/> kg		
Notify MD of wt. gain: <input type="checkbox"/> 2 lbs <input type="checkbox"/> 3 lbs/day or 5 lbs/wk; BP < _____ > _____ HR < _____ > _____		
Adjust rate only if weight changes by ≥ 10 lbs		
Access: <input type="checkbox"/> PICC <input type="checkbox"/> Tunneled Catheter <input type="checkbox"/> Implanted port <input type="checkbox"/> Other:		# of Lumens:
Catheter Maintenance: <input type="checkbox"/> Option Care Protocol <input type="checkbox"/> Other:		
<input type="checkbox"/> Additional Orders:		
<input type="checkbox"/> Lab orders: <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> OTHER		Call/Fax results to:
<input type="checkbox"/> NURSING:		
<ul style="list-style-type: none"> ✓ Instruct patient/caregiver in therapy management, and infusion pump operation ✓ Teach patient/caregiver: daily monitoring (wt., vital signs, abdominal girth), diet & fluid management, signs & symptoms of exacerbation, when & how to contact RN or Pharmacist ✓ Nurse to perform Central Vascular Catheter dressing change weekly and as needed ✓ Teach patient/caregiver appropriate flushing to additional lumens of Central Vascular Catheter, if applicable ✓ Instruct patient/caregiver to call 911 if symptoms are severe (unless patient is "DNR") ✓ Insert peripheral IV prn in the event of problems with the Central Vascular Catheter and notify ordering provider 		

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Physician Signature:	Date:
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PRESCRIBER INFORMATION		
PRESCRIBER NAME:	Direct Contact Number/extension:	
Specialty:	Hospital/Clinic:	
Address:	City, State:	Zip:
License:	NPI:	UPIN:

CONFIDENTIAL HEALTH INFORMATION: Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.