YOUR INTELLIGENT HEALTH COMPANY.

UBACARE

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: ☐ Demographics ☐ Insurance Info ☐ History & Physical ☐ Medication List ☐ Progress Notes		
Therapy Start Date:	Hospital & Room #:	

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

Prescription and Orders		
☐ Milrinone	Administer _____ mcg/kg/min	☐ Continuously via ambulatory infusion pump
☐ Dobutamine	Administer _____ mcg/kg/min	☐ Continuously via ambulatory infusion pump
☐ Dopamine	Administer _____ mcg/kg/min	☐ Continuously via ambulatory infusion pump

Dosing weight: (if different than actual wt): ☐ lb ☐ kg

Notify MD of wt. gain: ☐ **2 lbs** ☐ **3 lbs/day or 5 lbs/wk;** **BP <** _____ **>** _____ **HR <** _____ **>** _____

Adjust rate only if weight changes by ≥10 lbs

Access: ☐ PICC ☐ Tunneled Catheter ☐ Implanted port ☐ Other: **# of Lumens:**

Catheter Maintenance: ☐ Option Care Protocol Other:

☐ **Additional Orders:**

☐ **Lab orders:** ☐ BMP ☐ CMP ☐ CBC ☐ OTHER **Call/Fax results to:**

☐ **NURSING:**

- ✓ 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:**

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