HEART FAILURE INFUSION SERVICES ENROLLMENT/ORDER FORM

Patient Name:	**Date of Birth:**
Address:	

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies: ☐ NKDA	**DNR Status:** ☐ Order Received ☐ N/A

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: _____ ☐ lbs. ☐ kg *(if different than actual weight)*	**Notify MD of wt. gain: ☐ 2 lbs./day or 5 lbs./wk.**; **BP** < _____ > _____ **HR** < _____ > _____ ***Adjust dose and rate only if weight changes by ≥ 10 lbs.***	

Access: ☐ PICC ☐ Tunneled Catheter ☐ Implanted Port ☐ Other: # of Lumens:

☐ Additional Orders:

☐ Lab Orders: ☐ BMP ☐ CMP ☐ CBC ☐ Other: _____ Frequency: _____	Call/Fax results to:

☐ **NURSING**

- Provide IV catheter maintenance therapy for non-treatment days and to additional lumens of CVAD as outlined (orders below)
- Instruct/Teach: DO NOT routinely flush lumen used for continuous inotrope infusion.
- Initiate/maintain peripheral IV prn for CVAD troubleshooting (milrinone and/or dobutamine only), DO NOT INFUSE DOPAMINE PERIPHERALLY
- Indicate appropriate flushing protocol by checking the appropriate item(s)
- Provide all supplies necessary to instruct patient/caregiver on overall heart failure therapy administration and management.

☐ Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x 1 per incident of sluggish/occluded line. Qty: #2

☐ Skilled nurse to train patient/caregiver to self- administer medication, access/maintain central IV access (where applicable), monitor, and treat ADRs and PRN visits for additional patient needs r/t therapy, VAD, and education

Indicated Access Device to be Utilized	**NS Flush (0.9% NaCl)**	**Heparin**
☐ Peripheral IV ***When required, for milrinone and/or dobutamine ONLY***	☐ 2-3 mL pre/post infusion; maintenance 2-3 mL every 12 hours	☐ N/A ☐ 1-3 mL heparin (10 units/mL) every 24 hours
☐ PICC & Central Tunneled & Non-tunneled	☐ 5 ml pre/post use; 5 ml pre/10 ml post lab draw ☐ _____	☐ 3 - 5 ml (heparin 10 units/ml) post use or every 24 hours if not used ☐ _____
☐ Implanted Port	☐ 5 - 10 ml pre/post infusion ☐ 10 - 20 ml pre/ post lab draw ☐ _____	☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used ☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
☐ Valved Catheters: Chest, PICC, Midline	☐ 5 - 10 ml pre/post use ☐ 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

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

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

