

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/APlan 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 pumpDosing 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: _____

Call/Fax results to:

Frequency: _____

☐ 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
<input type="checkbox"/> Peripheral IV ***When required, for milrinone and/or dobutamine ONLY***	<input type="checkbox"/> 2-3 mL pre/post infusion; maintenance 2-3 mL every 12 hours	<input type="checkbox"/> N/A <input type="checkbox"/> 1-3 mL heparin (10 units/mL) every 24 hours
<input type="checkbox"/> PICC & Central Tunneled & Non-tunneled	<input type="checkbox"/> 5 ml pre/post use; 5 ml pre/10 ml post lab draw <input type="checkbox"/> _____	<input type="checkbox"/> 3 - 5 ml (heparin 10 units/ml) post use or every 24 hours if not used <input type="checkbox"/> _____
<input type="checkbox"/> Implanted Port	<input type="checkbox"/> 5 - 10 ml pre/post infusion <input type="checkbox"/> 10 - 20 ml pre/post lab draw <input type="checkbox"/> _____	<input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used <input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
<input type="checkbox"/> Valved Catheters: Chest, PICC, Midline	<input type="checkbox"/> 5 - 10 ml pre/post use <input type="checkbox"/> 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:

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