

HEART FAILURE INFUSION SERVICES ENROLLMENT/ORDER FORM

Patient Name:	Date of Birth:	Gender:
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Address:

Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
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Clinical Information

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

Plan of Care: Bridge to Transplant Bridge to VAD Bridge to Decision 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: _____ 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:

<input type="checkbox"/> Lab Orders: <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> Other: _____ Frequency: _____	Call/Fax results to:
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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

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:
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Address:	NPI:
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City, State:	Zip:	Office Contact:
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