HEART FAILURE INFUSION SERVICES ENROLLMENT/ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
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

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

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

Not valid for use for patients residing in Arizona, New York, and Wisconsin

