


HEART FAILURE INFUSION SERVICES ENROLLMENT/ORDER FORM

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

	Patient Name:		Date of Birth:	
	Address:			
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
Allergies: <input type="checkbox"/> NKDA	DNR Status: <input type="checkbox"/> Order Received <input type="checkbox"/> N/A
Plan of Care: <input type="checkbox"/> Bridge to Transplant <input type="checkbox"/> Bridge to VAD <input type="checkbox"/> Bridge to Decision <input type="checkbox"/> 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: _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg (if different than actual weight)	Notify MD of wt. gain: <input type="checkbox"/> 2 lbs./day or <input type="checkbox"/> 5 lbs./wk.; BP < _____ > _____ HR < _____ > _____ Adjust dose and rate only if weight changes by ≥ 10 lbs.	
Access: <input type="checkbox"/> PICC <input type="checkbox"/> Tunneled Catheter <input type="checkbox"/> Implanted Port <input type="checkbox"/> Other:	# of Lumens:	
<input type="checkbox"/> Additional Orders:		
Lab Orders: <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> Other: _____	Call/Fax results to:	
Frequency: _____		

NURSING

- Option Care Health to 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:

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