Wellscript
An Owens Company

CHICO
Phone: (530) 225-8898 | Fax: (530) 246-7366
REDDING
Phone: (530) 225-8898 | Fax: (530) 246-7366

Heart Failure Infusion Services Enrollment/Order Form

Referral Date:

If Medicare - please complete and return the Inotropic Data Collection Form

PATIENT INFORMATION

Patient Name:	Patient Phone:	DOB:
Address:	City, State:	Zip:
Caregiver Name:	Relationship:	Phone:
Please Include: ☐ Demographics ☐ Insurance Info ☐ History & Physical ☐ Medication List ☐ Progress Notes		
Therapy Start Date:	Hospital Room #:	

CLINICAL BACKGROUND

Primary Diagnosis: ☐ Heart Failure ☐ Other:		
Allergies: ☐ NKDA	☐ DNR Status ☐ Order Received ☐ N/A	
Ht: ☐ in ☐ cm	Wt: ☐ lb ☐ kg	
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: (if different than actual wt): ☐ lb ☐ kg

Notify MD of wt. gain: ☐ 2 lbs ☐ 3 lbs/day or 5 lbs/wk; BP< _____ > _____ HR< _____ > _____

Adjust rate only if weight changes by ≥ 10lbs

Access: ☐ PICC ☐ Tunneled Catheter ☐ Implanted port ☐ Other: **# of Lumens:**

Catheter Maintenance: ☐ Owens Protocol Other:

☐ **Additional Orders:**

☐ **Lab Orders:** ☐ BMP ☐ CMP ☐ ESR ☐ CRP ☐ CBC ☐ OTHER:_____ Call/Fax results to:_____

☐ **NURSING:**

- ✓ Instruct patient/caregiver in therapy management, and infusion pump operation
- ✓ Teach patient/caregiver: daily monitoring (wt., vital signs, abdominal girth), diet & fluid management, signs & symptoms of exacerbation, when & how to contact RN or Pharmacist
- ✓ Nurse to perform Central Vascular Catheter dressing change weekly and as needed
- ✓ Teach patient/caregiver appropriate flushing to additional lumens of Central Vascular Catheter, if applicable
- ✓ Instruct patient/caregiver to call 9 1 1 if symptoms are severe (unless patient is "DNR")
- ✓ Insert perphaeral IV prn in the event of problems with the Central Vascular Catheter and notify ordering provider

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

Physician Signature: **Date:**

PRESCRIBER INFORMATION

PRESCRIBER NAME:	Direct Contact Number/extension:	
Specialty:	Hospital/Clinic:	
Address:	City, State:	Zip:
License:	NPI:	UPIN: