PLEASE USE BALL POINT PEN PLEASE PRESS FIRMLY USE ACCEPTED ABBREVIATIONS

Date Time	Allergies:
	Please fill in all appropriate spaces. To cancel an order, draw a line through the entire order.
	Heart Failure Admission Order Set – Page 1 of 3
	1. Admit to: _____Med Surg _____ICU _____Telemetry _____Step Down Unit
	2. Obtain old records
	3. Consult: _____
	4. Vital signs _____
	5. Strict I&O
	6. Daily weights
	7. Oxygen via _____ at _____
	8. Pulse oximetry on admission and record and daily. Call physician if less than _____%.
	9. Activity: _____
	10. Diet: _____2 gm sodium _____No added salt _____Cardiac _____Restricted fat, no added salt
	_____Consistent Carb (ADA) _____Calorie Consistent Carb (ADA)
	_____Renal Diet _____gm Protein _____gm Potassium _____gm Sodium
	_____ml Fluid restriction _____Dietary Consult
	Other: _____
	Pre-albumin to be drawn on all admissions (Exceptions: Obstetrics, Pediatrics, Observation, and/or SPU).
	11. Consult Respiratory Therapy for Smoking Cessation Education/Counseling (If smoking in the past 12 Months)
	12. Foley catheter to straight drainage
	13. IV therapy: _____Saline Lock _____Fluid/rate: _____
	14. Obtain copy of Echocardiogram report, if done in the past 12 months.
	If unavailable, order Echocardiogram. Echo to be read by: _____
	*If echocardiogram done in the past 12 months a copy of the report must be on the chart within 24 hours.
	** **This order cannot be canceled.**
	15. (If not done in the ED) EKG on admission and in the AM
	16. (If not done in the ED) CBC, Complete metabolic profile, INR, BNP, MIP, and Fasting Lipid Profile.
	17. (If not done in the ED) _____PA/LAT Chest xray _____Portable chest xray
	18. Diuretics:
	Lasix (furosemide) _____mg po/IV (circle one) every _____hours
	Bumex (bumetanide) _____mg po/IV (circle one) every _____hours
	Demadex (torsemide) _____mg po every _____hours
	Zaroxolyn (metolazone) _____mg po every _____hours
	_____None
	19. Beta Blockers:
	Coreg (carvedilol) _____mg po twice daily (breakfast and dinner)
	_____
	Physician Signature Date/Time
	ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT IDENTICAL IN DOSAGE FORM AND CONTENT OF ACTIVE INGREDIENTS MAY BE ADMINISTERED ACCORDING TO FORMULARY POLICY UNLESS A PHYSICIAN WRITES "BRAND MEDICALLY NECESSARY" AFTER EACH MEDICATION ORDER.

patient identification sticker

PLEASE USE BALL POINT PEN PLEASE PRESS FIRMLY USE ACCEPTED ABBREVIATIONS

Date Time	Allergies:
	Please fill in all appropriate spaces. To cancel an order, draw a line through the entire order.
	Heart Failure Admission Order Set - Page 2 of 3
	19. Beta Blockers Continued:
	Lopressor (metoprolol) _____mg po every _____hours
	Toprol XL (metoprolol XL) _____mg po every _____hours
	Note: Only Coreg (carvedilol) & Toprol XL (metoprolol XL) have indications for heart failure.
	None – Reason must be specified by checking below:
	_____EF equal to or greater than 40% _____Allergy intolerance _____Hypotension _____Bradycardia
	_____ Asthma _____ COPD _____ Echo pending _____ Other *(specify):*
	20. ACE Inhibitors:
	Vasotec (enalapril) _____mg po/IV (circle one) every _____hours
	Zestril/Prinivil (lisinopril) _____mg po every _____hours
	Capoten (captopril) _____mg po every _____hours
	Altace (ramipril) _____mg po every _____hours
	Monopril (fosinopril) _____mg po every _____hours
	Accupril (quinapril) _____mg po every _____hours
	Lotensin (benazepril) _____mg po every _____hours
	None – Reason must be specified by checking below:
	_____EF equal to or greater than 40% _____Allergy intolerance _____Hypotension _____Renal insufficiency
	_____On Angiotensin II Receptor Blocker _____ Echo pending _____ Other *(specify):*
	21. Angiotensin II Receptor Blockers:
	Cozaar (losartan) _____mg po every _____hours
	Diovan (valsartan) _____mg po every _____hours
	Avapro (irbesartan) _____mg po every _____hours
	Atacand (candesartan) _____mg po every _____hours
	Micardis (telmisartan) _____mg po every _____hours
	Benicar (olmesartan) _____mg po every _____hours
	None – Reason must be specified below:
	Note: Only Diovan (valsartan) & Atacand (candesartan) have indications for heart failure.
	_____EF greater than or equal to 40% _____Allergy intolerance _____Hypotension _____Renal insufficiency
	_____On ACE _____ Echo pending _____ Other *(specify):*
	22. Other Medications:
	Natrecor (nesiritide) IV bolus dose of _____micrograms/kg
	Natrecor (nesiritide) IV Infusion at _____ micrograms/kg/minute
	_____
	Physician Signature Date/Time
	ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT IDENTICAL IN DOSAGE FORM AND CONTENT OF ACTIVE INGREDIENT MAY BE ADMINISTERED ACCORDING TO FORMULRY POLICY UNLESS A PHYSICIAN WRITES "BRAND NAME MEDICALLY NECESSARY" AFTER EACH MEDICATION ORDER.

patient identification sticker

PLEASE USE BALL POINT PEN PLEASE PRESS FIRMLY USE ACCEPTED ABBREVIATIONS

Date Time	Allergies:
	Please fill in all appropriate spaces. To cancel an order, draw a line through the entire order.
	Heart Failure Admission Order Set - Page 3 of 3
	22. Other Medications Continued:
	Digoxin _____mg po/IV (circle one) daily
	Potassium chloride _____mEq po every _____hours
	Inspra (eplerenone) _____mg po daily
	Aldactone (spironolactone) _____mg po every _____hours
	ASA (acetylsalicylic acid) _____mg po daily
	Hydralazine (Apresoline) _____mg po/IV every _____hours
	Nitroglycerin Infusion (200mcg/ml) at _____micrograms/minute
	23. Antilipemics:
	Lipitor (atorvastatin calcium) _____mg po daily
	Pravachol (pravastatin) _____mg po daily
	Zocor (simvastatin) _____mg po daily
	Zetia (ezetimibe) _____mg po daily
	24. DVT Prophylaxis: This section can NOT be cancelled.
	CBC & Platelet count every other day automatically if patient is on Heparin, Enoxaparin, or Fondaparinux.
	_____ DVT prophylaxis contraindicated. REASON:
	_____ No prophylaxis other than early ambulation.
	_____ Heparin 5000 units subcutaneously every (8) hours
	_____ Enoxaparin (Lovenox) 40 mg subcutaneously daily
	_____ Enoxaparin (Lovenox) 30 mg subcutaneously daily (CrCl < 30 ml/min)
	_____ Flowtrons
	_____ Other:
	_____
	Physician Signature Date/Time
	ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT IDENTICAL IN DOSAGE FORM AND CONTENT OF ACTIVE INGREDIENT MAY BE ADMINISTERED ACCORDING TO FORMULARY POLICY UNLESS A PHYSICIAN WRITES "BRAND NAME MEDICALLY NECESSARY" AFTER EACH MEDICATION ORDER.

patient identification sticker

CHF DISCHARGE INSTRUCTION FORM

Medication	Dose	Time of Day	Route	Next Dose Due

Activity & Restrictions

1. Avoid intense exercise
2. Space out your activities and rest or stop if any symptoms occur
3. Get plenty of sleep
4. Avoid heavy lifting (for most people this is over 20 pounds)
5. Avoid very hot and very cold temperatures
6. Other:_____

Diet

1. Watch salt intake (no more than 1 tsp. of salt per day)
2. Watch your fluid intake (no more than 8 cups per day)
3. Watch your alcohol intake (no more than 1-2 servings per week)
4. Watch your caffeine intake (no more than 1 serving per day)
5. Other:_____

Special Instructions - Signs and Symptoms to Report

1. Call your doctor within 8-12 hours if:
   a. 3-4 pound weight gain
   b. New shortness of breath
   c. Wake up with a cough or notice you have constant cough
   d. Increase in weakness or fatigue
   e. Swelling of hands and feet or stomach bloating
2. Call your doctor immediately if:
   a. Chest pain or pressure
   b. Fast Heartbeat
   c. Dizziness, fainting
   d. Any unusual bleeding or bruising

Safe Effective Use of Medical Equipment ☐ **Non Applicable**

_____

Wound & Dressing Care

_____

Smoking

If you smoke — Stop. Smoking causes additional injury to your heart. If you are ready to quit smoking or want more information, discuss this with your physician

Follow Up - Please Bring This Copy With You

1. Keep all doctor appointments
2. Keep any/all appointments for blood work, tests and studies

Call Dr. _____ for appointment in _____ Days/Weeks Phone:_____

Call Dr. _____ for appointment in _____ Days/Weeks Phone:_____

Call Dr. _____ for appointment in _____ Days/Weeks Phone:_____

Home Health Follow Up With:_____

Immunization Screenings completed: ☐ Yes ☐ No ☐ N/A (Age less than 65)

Immunizations received pre-discharge: ☐ Pneumovax ☐ Influenza

I have received a copy of the above instructions and understand the information listed:

Patient / Significant Other Signature: _____ Relationship:_____

Nurse Signature: _____ Date: _____

Physician Signature:_____ Date: _____

CHF DISCHARGE INSTRUCTION FORM

Hazleton General Hospital
700 East Broad Street
Hazleton, PA 18201

ADDRESSOGRAPH

IN1080 10/08

White - Medical Records • Canary - Patient • Pink - Physician

After you leave the hospital, you should follow these instructions. These instructions are necessary for continuing your medical care.

Congestive Heart Failure Teaching/Discharge Instructions

Medication

- Make a schedule and take your medicine exactly as instructed.
- Check with your doctor before taking any other medicines including over-the-counter medicines. They may interfere with your heart medicine.

Diet

- Watch your salt intake (no more than 1 teaspoon of salt per day).
- Watch your fluid intake (no more than 64 oz (8 cups) per day).
- Watch your alcohol intake (no more than 1 to 2 servings per week).
- Watch your caffeine intake (no more than 1 caffeinated beverage per day).

Weight

- Weigh yourself at the same time every day.
- If you gain 3 to 4 pounds within 2 days, call your doctor. You may be holding fluid.

Activity

- Avoid intense exercise.
- Space out your activities and rest or stop if any symptoms occur.
- Get plenty of sleep.
- Avoid heavy lifting (for most people this is over 20 pounds).
- Avoid very hot and very cold temperatures.

Symptoms

CALL your doctor WITHIN 8 to 12 hours if:

- 3 to 4 pound weight gain.
- New shortness of breath.
- Wake up with a cough or notice you have a constant cough.
- Increase weakness or fatigue.
- Swelling of hands and feet or stomach bloating.

CALL your doctor IMMEDIATELY if:

- Chest pain or pressure.
- Fast heartbeat.
- Dizziness, fainting.
- Any unusual bleeding or bruising.

Follow-up

- Keep all doctors appointments.
- Keep any/all appointments for blood work, tests and studies.

If you smoke --- STOP. Smoking causes additional injury to your heart. If you are ready to quit smoking or want more information, discuss this with your physician.

☐ Copy given to patient ☐ CHF educational booklet given to patient

List below all of the Patient's Medications **Prior To Admission** Including all Herbal's, Minerals, Vitamins, and OTC Medications.

Prohibited Abbreviations: U, IU, CC, QD, QOD, QID, AU, AS, AD, MS, MSO4, MgSO4

Source of Medication List: (Check all that apply)

☐ Patient medication list ☐ Patient/Family Recall ☐ Medication Administration Record From Transfer Facility

☐ Physician Office List ☐ Patient Not Known To Be On Any Medications

☐ Other _____

Unable to complete information on this form due to:

☐Patient confused ☐ Patient Nonverbal ☐ No family/significant others to contact.

Pharmacy(s) Used by Patient: List name(s)		Practitioners Seen by Patient: List name(s)	

Allergies:_____

_____

Patient is: Pregnant? ☐ Yes ☐ No ☐ Unknown; Breastfeeding? ☐ Yes ☐ No

Medication/Dose	Route	Frequency	Last Dose Date/Time	Mark an X in the appropriate column to Continue/ Discontinue medications on admission	
				Continue	Discontinue
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

Medication List obtained by: _____(Signature/Title)_____(Date/Time)

Reviewed by RN: _____(Signature/Title)_____(Date/Time)

Telephone Orders: _____/_____/_____/_____

Physician Name RN Signature Date/Time RB(Initial)

_____/_____

Physician Signature Date/Time

Fax to Pharmacy. File under Physicians Orders.

Medication Reconciliation Orders

☐ Change in level of care ☐ Discharge

In review of the current medication profile dated/timed (_____/_____) and the patient's admission medication listing, please take the following actions:

☐ Continue all medication as listed on current medication profile

☐ Continue all medication as listed on current medication profile with the following changes, discontinuations, or additions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Telephone Orders: _____/_____/_____/_____

Physician Name RN Signature Date/Time RB (Initial)

Physician signature: _____/_____

Physician Name Date/Time