vitalcare of SOUTH DALLAS

Heart Failure Inotropic Treatment Form

☐ Home Infusion ☐ Alternate Site of Care

P 945.212.3707 | F 866.790.3580

Patient Information

Patient name: _____ DOB: _____

Sex: ☐ Female ☐ Male SSN: _____

Language: _____ Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

Caregiver name: _____ Relation: _____

Local pharmacy: _____ Phone: _____

Insurance plan: _____ Plan ID: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber Information

Prescriber name: _____

NPI: _____

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Alternate: _____

Fax: _____

Email address: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10 Codes: _____ **Description** _____

Data Collection:

Results of hemodynamic monitoring:

	Cardiac Index	Pulmonary capillary wedge pressure	Date
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____

Cardiac drugs provided immediately (digoxin, diuretics, vasodilators) prior to inotrope infusion (include drug, dose, and frequency)

_____

_____

_____

Does this represent maximum tolerated doses of these? ☐ Yes ☐ No

Breathing status (check one in each column)

	Prior to inotrope infusion	At time of discharge
No dyspnea on exertion	☐	☐
Dyspnea on moderate exertion	☐	☐
Dyspnea on mild exertion	☐	☐
Dyspnea at rest	☐	☐

If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? ☐ Yes ☐ No

Additional information _____

If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required? ☐ Yes ☐ No

Additional information _____

Is the patient capable of going to the physician for outpatient evaluation? ☐ Yes ☐ No

Is routine electrocardiographic monitoring required in the home? ☐ Yes ☐ No

Has the patient been stabilized on the prescribed inotrope dose for 24 hours? ☐ Yes ☐ No

Patient's name: _____ **Date of Birth:** _____

Infusion Orders

The maintenance dose will be established and patient stabilized on maintenance dose before first home infusion. Titration of the maintenance dose should not be done in home setting. Safe doses of the drugs should fall within ranges noted below. Any doses falling outside of these ranges should be double checked with a Vital Care Infusion Pharmacist.

Dobutamine : 2.5-10 mcg/kg/min

Milrinone 0.375-0.75 mcg/kg/min

Ordered Medication: _____

Dose _____mcg/kg/min

Clinical rationale for the prescription outside the above dosing ranges _____

Dosing weight: _____ kg

☐ Continuous ☐ Intermittent Frequency _____ Duration: _____

☐ Pharmacy to dispense 1 pump (E0779, E0781, or E0791) 1 spare pump for emergency. The quantity of infusion pump supplies will match the primary therapy requirements.

Other accessories or options: _____

Dose adjustment: Pharmacy to contact the prescriber every _____ week(s).

Dosing will be adjusted under the direction of a physician based upon the patient's response.

IV access (check one) ☐ PICC ☐ Midline ☐ Other_____ # of lumens _____

Flush orders/Instruction:_____

Note: the quantity and refills for flushing orders will match therapy requirements.

(Do not use Heparin flush with Dobutamine: Incompatible)

Nursing Orders:

☐ If no central IV access, RN to insert peripheral IV, rotate site as needed.

☐ Other: _____

Lab Orders: If no frequency selected we will assume one time order

☐ CBC w/diff	☐ at baseline, and weekly	☐ every _____
☐ CMP	☐ at baseline, and weekly	☐ every _____
☐ Magnesium, Phosphorus	☐ at baseline, and weekly	☐ every _____
☐ BMP	☐ weekly (if no CMP ordered weekly)	☐ every _____
☐ _____	☐ one time ☐ weekly	☐ every _____
☐ _____	☐ one time ☐ weekly	☐ every _____

Prescriber's Signature (stamp signature not allowed) DEA Number (if required for controlled substances): _____

_____ / _____ Date:_____

Dispense as Written Substitution Permitted

I authorize Vital Care of South Dallas and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Vital Care of South Dallas