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 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
   Zaroxylon (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.
<table>
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<tr>
<th>Date</th>
<th>Time</th>
<th>Allergies:</th>
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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**

---

**patient identification sticker**

---

**Hazleton General Hospital**

700 East Broad Street, Hazleton, PA 18201

**Heart Failure Orders - Page 2 of 3**

P-0077PG2- 0608
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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Time of Day</th>
<th>Route</th>
<th>Next Dose Due</th>
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### 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:

### 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

### 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:

### 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.

<table>
<thead>
<tr>
<th>Pharmacy(s) Used by Patient: List name(s)</th>
<th>Practitioners Seen by Patient: List name(s)</th>
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**Allergies:**

________________________

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

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<th>Route</th>
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Medication List obtained by: ___________________________ (Signature/Title) ___________________________ (Date/Time)
Reviewed by RN: ___________________________ (Signature/Title) ___________________________ (Date/Time)

<table>
<thead>
<tr>
<th>Telephone Orders:</th>
<th>Physician Name</th>
<th>RN Signature</th>
<th>Date/Time</th>
<th>RB(Initial)</th>
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Physician Signature ___________________________ Date/Time ___________________________ Date/Time

Fax to Pharmacy. File under Physicians Orders.

Hazleton General Hospital
700 East Broad Street, Hazleton, Pa. 18201

**Inpatient Units**
**Admission Medication Reconciliation**
P-0142-052907

Page ___ of ___ 05292007
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:

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

Telephone Orders: ______________________________________ / ____________ / __________ / __________ / __________

Physician Name  RN Signature  Date/Time  RB (Initial)

Physician signature: ______________________________________ / ____________

Physician Name  Date/Time

Hazleton General Hospital
700 East Broad Street, Hazleton, PA 18201

Medication Reconciliation Orders
P-0144-0507