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<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 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

   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.
PLEASE USE BALL POINT PEN  PLEASE PRESS FIRMLY  USE ACCEPTED ABBREVIATIONS

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 \( \text{mg po/IV (circle one)} \) daily
- Potassium chloride \( \text{mEq po every hours} \)
- Inspra (Eplerenone) \( \text{mg po daily} \)
- Aldactone (Spironolactone) \( \text{mg po every hours} \)
- ASA (Acetylsalicylic acid) \( \text{mg po daily} \)
- Hydralazine (Apresoline) \( \text{mg po/IV every hours} \)
- Nitroglycerin Infusion (200mcg/ml) at micrograms/minute

### 23. Antilipemics:
- Lipitor (Atorvastatin calcium) \( \text{mg po daily} \)
- Pravachol (Pravastatin) \( \text{mg po daily} \)
- Zocor (Simvastatin) \( \text{mg po daily} \)
- Zetia (Ezetimibe) \( \text{mg po daily} \)

### 24. DVT Prophylaxis: This section can NOT be cancelled.

CBC & Platelet count every other day automatically if patient is on Heparin, Enoxaparin, or Fondaparinux.

- \( \text{DVT prophylaxis contraindicated. REASON:} \)
- \( \text{No prophylaxis other than early ambulation.} \)
- \( \text{Heparin 5000 units subcutaneously every (8) hours} \)
- \( \text{Enoxaparin (Lovenox) 40 mg subcutaneously daily} \)
- \( \text{Enoxaparin (Lovenox) 30 mg subcutaneously daily (CrCl < 30 ml/min)} \)
- \( \text{Flowtrons} \)
- \( \text{Other:} \)

---

**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.
# 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: ________________

## 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
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>
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<tr>
<th>Pharmacy(s) Used by Patient:</th>
<th>List name(s)</th>
<th>Practitioners Seen by Patient:</th>
<th>List name(s)</th>
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Allergies:__________________________

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

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<tr>
<th>Medication/Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Last Dose</th>
<th>Date/Time</th>
<th>Continue</th>
<th>Discontinue</th>
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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:

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<th>Action</th>
<th>Description</th>
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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