



## Physician Orders Heart Failure Orders

PATIENT ID LABEL

**I HEREBY AUTHORIZE THE PHARMACY TO DISPENSE A GENERIC EQUIVALENT UNLESS THE PARTICULAR DRUG IS CIRCLED.**

**INSTRUCTIONS TO COMPLETE ORDER SET:** *Orders with check blocks are optional and must be specifically check marked* to be considered part of the authenticated order set. *Orders without check blocks are routine* and will be automatically performed as part of the authenticated order set. All statements ending in a colon or containing a blank must be completed to be considered a valid order.

DATE ORDERED	TIME ORDERED	TIME NOTED & INITIALS	ORDERS
			<b>Admitting Physician:</b>
			<b>Admit to Unit:</b> _____ <b>Telemetry</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
			<b>Diagnosis:</b> Heart Failure, _____
			EF _____ %      Date of Evaluation _____ <input type="checkbox"/> Not Known
			<b>Condition:</b>
			<b>Allergies:</b> <input type="checkbox"/> NKA <input type="checkbox"/> Other:
			<b>Vital Signs:</b>
			Notify MD if SBP < _____ mm Hg, or > _____ mm Hg
			<b>Oxygen Therapy:</b> 2 - 6 L / MIN via NC to maintain SpO2 ≥ 92%
			<b>Weight on admission and Daily</b>
			<b>Strict Intake / Output:</b> <input type="checkbox"/> Foley PRN difficulty voiding or pt. at high risk of falling
			<b>Activity:</b> <input type="checkbox"/> Bedrest <input type="checkbox"/> OOB to chair or Ambulate TID <input type="checkbox"/> Other:
			<b>Code Status:</b> <input type="checkbox"/> Full Code <input type="checkbox"/> No Intubation <input type="checkbox"/> DNR (No Resuscitation)
			<b>Diet:</b> <input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> Other:
			<b>Fluid Restriction:</b> <input type="checkbox"/> 1 L / 24 hrs <input type="checkbox"/> 1.5 L / 24 hrs <input type="checkbox"/> 2 L / 24 hrs <input type="checkbox"/> None
			<b>IV:</b> <input type="checkbox"/> Saline Lock <input type="checkbox"/> Other:
			<b>Labs (if not done in ED)</b> <input type="checkbox"/> Cardiac Panel on admission <input type="checkbox"/> Stat CBC
			<input type="checkbox"/> CK-MB Q8H x _____ <input type="checkbox"/> Stat Troponin-1
			<input type="checkbox"/> Stat PT / INR <input type="checkbox"/> BMP in AM
			<input type="checkbox"/> Stat PTT <input type="checkbox"/> Magnesium in AM
			<input type="checkbox"/> Digoxin <input type="checkbox"/> TSH in AM
			<input type="checkbox"/> B-Natriuretic Peptide Now and at discharge
			<input type="checkbox"/> Fasting Lipid Profile in AM
			<b>Other Labs:</b>
			<b>Physician Signature / Title</b>

**Narcotics Automatically Discontinued After 96 Hours - Must be Reordered**

**PROHIBITED ABBREVIATIONS:** U, IU, QD, QOD, MS, MSO<sub>4</sub>, MgSO<sub>4</sub>, µg, d, NCS, NCB;  
Use of trailing zero's after decimal point; Lack of preceding zero before decimal point



5 5 4 6 2



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DATE ORDERED	TIME ORDERED	TIME NOTED & INITIALS	ORDERS
			Chest Xray (if not done in ED)
			12 Lead ECG on admission (if not done in ED) and daily x 1 day
			Echocardiogram: <input type="checkbox"/> Transthoracic Echo <input type="checkbox"/> Echo with Doppler
			Other Tests:
			<b>MEDICATIONS:</b>
			Vasodilators:
			ACE Inhibitor:
			<input type="checkbox"/> Contraindication for ACE Inhibitor (specify):
			Angiotensin Receptor Blocker (ARB):
			<input type="checkbox"/> Contraindication for ARB (specify):
			Nitrate:
			Beta Blocker:
			<input type="checkbox"/> Beta-Blocker Intolerant (specify):
			Morphine Sulfate:
			Diuretic:
			Aldosterone Antagonist:
			Nesiritide for heart failure: <input type="checkbox"/> See Nesiritide Order Sheet (required)
			Digoxin for heart failure:
			Analgesia: <input type="checkbox"/> Acetaminophen 650 mg PO Q4H PRN mild pain
			<input type="checkbox"/> Nitroglycerin 0.4 mg SL Q5 mins x 3 PRN chest pain
			<input type="checkbox"/> Narcotic:
			GI Prophylaxis: <input type="checkbox"/> Ranitidine 150 mg PO daily <input type="checkbox"/> Other:
			DVT Prophylaxis: <input type="checkbox"/> Heparin 5000 units SC Q8H <input type="checkbox"/> Lovenox 40 mg SC daily
			<input type="checkbox"/> External Compression Device <input type="checkbox"/> None (pt. low risk)
			Physician Signature / Title

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