BC's HEART FAILURE NETWORK
Quality care for quality life.

Health Authority Logo

Addressograph

Heart Failure: Order Set

Allergies:

Admit to: ☐ CCU ☐ ICU ☐ Telemetry ☐ Medical

MRP:

☐ New onset of Heart Failure ☐ Exacerbation of Chronic Heart Failure

☐ Code Status (*per hospital policy*)

☐ Old charts retreived

☐ Pharmanet Search

☐ Establish IV

☐ Establish Saline Lock

Diagnostic Tests

☐ Assessment of LV function within the last 18 months BEFORE admission date or within 30 days from ED visit- ***QUALITY INDICATOR***

- ☐ Yes _____ Obtain for chart
- ☐ No_____
  - ☐ Book: Echo MIBI MUGA (circle)

☐ CXR ***QUALITY INDICATOR ORDER AS PART OF INITIAL EVALUATION***
☐ BNP or NT-proBNP
☐ Cardiac Enzymes
☐ Liver function tests

☐ CBC
☐ INR
☐ Electrolytes ***QUAILITY INDICATOR- ORDER DAILY SODIUM, POTASSIUM***
☐ BUN ***QUAILITY INDICATOR- ORDER DAILY***
☐ Creatine ***QUAILITY INDICATOR- ORDER DAILY***
☐ Uric Acid
☐ Glucose
☐ TSH
☐ Other _____

Treatments

☐ Fluid restriction
- 1500 ml
- Other_____

☐ Daily weights (*in the morning)*

☐ Diet
- Na_____ (< 2000mgrestriction)
- Other_____
- Record
  - ☐ Intake ☐ Output x 24 hrs

☐ O2 to Maintain O@ Sats at _____

☐ VS (*as per hospital unit protocol*)

☐ Activity (*as per hospital unit protocol)*

☐ Fall assessment screening

Signature: _____College Licence #: _____ Date: _____Time:_____

Heart Failure Medications: *(Note: Physician needs to fill out specialty authority form for Carvedilol and ARB's)*
https://www.health.gov.bc.ca/exforms/pharmacare/5328fil.pdf *1-250-952-1216 (direct) or 1-877-657-1188 (prompts)*

☐ BETA BLOCKER

Beta blocker:_____

HOLD for heart rate less than 50 bpm
If not ordered, indicate contraindication:

- ☐ Allergy
- ☐ Bradycardia
- ☐ Hypotension
- ☐ Cardiogenic Shock
- ☐ Reactive airway disease (Asthma)
- ☐ 2nd or 3rd degree heart block in ECG
- ☐ Other:_____

☐ ANGIOTENSIN CONVERTING ENZYME (ACE) OR ANGIOTENSIN RECEPTOR BLOCKER (ARB)-***QUALITY INDICATOR***

For LVSD:

ACEI _____mg PO_____

ARB :_____mg PO _____

Hydralazine _____mg PO _____

HOLD for symptomatic hypotension or systolic BP less than _____ (mmHg)

If neither ACE nor ARB ordered, indicate contraindication:

- ☐ ACEI allergy
- ☐ ARB allergy
- ☐ Hypotension
- ☐ Known adverse reaction ☐ Cough
- ☐ Aortic stenosis, moderate/severe ☐ Hyperkalemia
- ☐ Renal insufficiency (Creat, eGFR)

☐ Diuretic

- ☐ Furosemide mg PO/IV X _____ (frequency/duration)
- ☐ Furosemide IV infusion _____ mg/h
- ☐ Metalozone _____mg daily 30 min prior to am dose of Furosemide
  - ☐ Hold if am weight less than target weight of _____lbs _____kg
- ☐ Spironolactone _____mg PO daily

☐ DVT/PE Prophylaxis (*per hospital protocol*)

☐ GI meds _____

☐ Bowel meds _____

☐ HS sedations _____

☐ Laxatives _____

☐ Analgesics _____

Other_____

Signature: _____College Licence #: _____ Date: _____Time:_____

Refer to (or consult)

- ☐ Cardiologist (on call DR or current cardiologist)
- ☐ Palliative care
- ☐ Nephrology
- ☐ Dietitian
- ☐ Social Work
- ☐ Occupational Health
- ☐ Physiotherapy
- ☐ Spiritual care
- ☐ Mental health
- ☐ Other _____

☐ **Patient Education Check list and Discharge Instruction-** ***QUALITY INDICATOR***

- ☐ Daily weight
- ☐ Fluid restriction
- ☐ Sodium restriction
- ☐ Activity guidelines
- ☐ Advance Directive
- ☐ Smoking cessation if applicable
- ☐ Discharge weight_____ lbs_____ kg
- ☐ Immunizations
- ☐ Medications outlined dosages and teaching
- ☐ Who to call for treatment advice/questions/problems
  - Add www.bcheartfailure.ca

Appointments

- ☐ Booked for GP
- ☐ Booked for Specialist appointment
- ☐ Referral form sent to Heart Function Clinic
- ☐ Registered into: Healthy Heart Program or Cardiac Rehabilitation:

  Start date _____ time_____
- ☐ Investigative out pt tests

  Specify _____

Signature: _____College Licence #: _____ Date: _____Time:_____

Key Elements that should be on a "Discharge Transition Tool" Form
D/C form from Hospital form Faxed it to primary care physician or Nurse Practitioner's and a copy is given to pt and a copy stays in Pt chart

Discharge diagnosis: *(Filled in by RN)*	**Admission date:** *(Filled in by Unit Clerk)*	**Discharge Date:** *(Filled in by Unit Clerk)*

Pt education and Discharge Instruction *(Filled in by RN)*

- ☐ Daily weight
- ☐ Fluid _____ less than 1500 ml
- ☐ Salt _____ less than 2000mg
- ☐ Activity
- ☐ S& S of worsening Heart Failure
- ☐ Smoking cessation if applicable
- ☐ Discharge weight _____
- ☐ Medications outlined dosages and teaching
- ☐ Avoid Non Steroidal Anti Inflammatory drugs

Patient Specific Discharge Parameters *(Filled in by RN)*

- ☐ NYHA class _____
- ☐ B/P: Lying_____ Standing_____
- ☐ P _____
- ☐ Discharge WT: _____
- ☐ Goal WT: _____
- ☐ Date with value for
  - Creatinine _____
  - K+ _____
  - eGFR _____
  - INR _____

Test Results *(Filled in by RN)*

- ☐ Documented EF % _____ By: Echo, MIBI, MUGA (circle)
- ☐ ECG Rhythm _____

Follow up Labs tests *(Filled in by Unit Clerk)*

Primary care Physician to arrange at patient 1st visit (after D/C)

- ☐ Test _____ Where _____
  Test_____ Where _____

Appointments/Referrals *(Filled in by Unit clerk)*

- ☐ Booked for Primary Care Physician/NP Date: _____ Time: _____
- ☐ Booked for Specialist Date: _____Time: _____
- ☐ Referral form sent to Heart Function Clinic
- ☐ Investigative out pt tests _____
  - Booked: _____

Medications: please refer to the medication prescription form

Procedures Completed *(Filled in by Unit Clerk)*

☐ Heart Catheterization ☐ Angioplasty	☐ Echo, ☐ MUGA	☐ Pacemaker ☐ Other	

Form faxed to Patients Primary Care Physician *(Filled in by Unit Clerk)*

Date: _____

Name of GP:_____

Fax # _____

Signature of person faxing form: _____

Signature: _____College Licence #: _____ Date: _____Time:_____

Discharge Prescription

Qualified to use:
Cardiologists/ Cardiac Surgeons/Internists/Family Practice Physicians/ Nurse Practitioners/Pharmacists

When filling this prescription please take this prescription and all your current medication to the pharmacy

ACE Inhibitors/ARB's *(Special authority needed for ARB's)*

Ramipril _____

Other_____

Beta Blockers

Carvedilol _____ *(Special authority needed)*

Metoprolol _____

Other _____

Statins

Atorvastatin _____

Rosuvastatin _____

Other_____

Diuretics

Furosemide _____

Hydrochlorothiazide _____

Spironolactone _____

Other _____

Antiarrhythmics

Amiodarone _____

Digoxin _____

Other _____

Special Authority :
https://www.health.gov.bc.ca/exforms/pharmacare/5328fil.pdf
or call 1-250-952-1216 (direct) or 1-877-657-1188 (prompts)

Anticoagulants/Antiplatelets

Clopidogrel _____ min duration _____

(DES 12/12 BMS 1/12)

EC ASA _____

Warfarin _____ Target INR _____

Other _____

Calcium Channel Blockers

Amlodipine _____

Other _____

Hypoglycemics

Gliclazide _____

MetFORMIN _____

Insulin _____

Other _____

Nitrates

Nitrospray _____

Nitropatch _____

NitroGLYCERIN SL _____

Antacids

Ranitidine 150mg PO BID

Other _____

Supply _____ Repeat _____

Other Medications: (Including home medications to be continued)

_____

_____

_____

Signature: _____College Licence #: _____ Date: _____Time:_____