

# CONGESTIVE HEART FAILURE ORDER SET

Date	Time	Complete top portion with each Level of Care change. Indicate order with a Check Mark.
		<input type="checkbox"/> Outpatient Procedure: _____ (procedure) for _____ (medical reason).
		<input type="checkbox"/> Place in Outpatient Observation Services for _____ (medical reason).
		<input type="checkbox"/> Admit as Inpatient for _____ (medical reason).

Physician Signature: \_\_\_\_\_

- Observation status to \_\_\_\_\_ .  
 Admit to \_\_\_\_\_ .

**Etiology of Heart Failure**

- CAD  
 HTN  
 Valvular heart disease  
 Cardiomyopathy  
 Other \_\_\_\_\_

**Nursing care:**

- Vital signs \_\_\_\_\_  
 Activity as tolerated  
 Consult Physical Therapy to evaluate and treat  
 Daily weights  
 I/O every shift  
 Heparin lock  
 Supplemental oxygen \_\_\_\_\_ , maintain pulse oximetry at \_\_\_\_\_  
 Notify MD if pulse oximetry less than \_\_\_\_\_  
 Diet \_\_\_\_\_  
 Fluid restriction \_\_\_\_\_ daily  
 Foley to CD

**Lab studies:**

- CBC \_\_\_\_\_  
 CMP \_\_\_\_\_  
 Magnesium \_\_\_\_\_  
 BMP \_\_\_\_\_  
 INR \_\_\_\_\_  
 BNP \_\_\_\_\_  
 Chest X-ray (choose one below)  
 Chest PA and Lateral \_\_\_\_\_  
 Portable \_\_\_\_\_

- OR-** \_\_\_\_\_ Diagnosis \_\_\_\_\_  
 Echocardiogram to be read by \_\_\_\_\_ Diagnosis \_\_\_\_\_  
 Obtain last 2-D Echo if done within the last year  
 Digoxin level \_\_\_\_\_  
 Chest pain panel \_\_\_\_\_ and repeat at \_\_\_\_\_

**Medications:**

- Beta Blockers Held/not given due to contraindication of: \_\_\_\_\_  
 Beta Blockers:  
 Carvedilol (Coreg) \_\_\_\_\_  
 Metoprolol (Lopressor) \_\_\_\_\_  
 Metoprolol sustained release (Toprol XL) \_\_\_\_\_  
 Atenolol (Tenormin) \_\_\_\_\_  
 Other \_\_\_\_\_

**CONTINUED ON NEXT PAGE**

Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PROHIBITED ABBREVIATION	REQUIRED TERM	PROHIBITED ABBREVIATION	REQUIRED TERM
ug	<b>Write</b> Microgram	1.0	<b>Write</b> 1. Do not use zero after decimal point
qd, q.d.	<b>Write</b> Daily	Zero after decimal point	
qod	<b>Write</b> Every Other Day or Every 48 hrs	MS	<b>Write</b> Morphine
U or u	<b>Write</b> Units	MgSO4, MSO4	<b>Write</b> Magnesium sulfate or Morphine sulfate
.5	<b>Write</b> 0.5 - make sure you use preceding 0	IU	<b>Write</b> International units
No zero before decimal point		OS, OD, OU	<b>Write</b> Left or right eye or both eyes
		AS, AD, AU	<b>Write</b> Left or right ear or both ears



ST. VINCENT CHARITY  
MEDICAL CENTER

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PATIENT LABEL

**Medications Continued:**

- ACE inhibitor Held/not given due to contraindication of: \_\_\_\_\_
- ACE inhibitor:
- Captopril (Capoten) \_\_\_\_\_
  - Enalapril (Vasotec) \_\_\_\_\_
  - Lisinopril (Prinivil)/(Zestril) \_\_\_\_\_
  - Other \_\_\_\_\_

*Or if ACE-I contraindicated use ARB*

- Angiotensin II Receptor Blockers Held/not given due to contraindication of: \_\_\_\_\_
- Angiotensin II Receptor Blockers:
- Losartan (Cozaar) \_\_\_\_\_
  - Valsartan (Diovan) \_\_\_\_\_

**Additional Medications:**

- Aspirin 325 mg enteric coated one tablet by mouth daily
- DVT Prophylaxis:
- Heparin 5000 units subcutaneous every 8 hours
  - OR-**
  - Heparin 5000 units subcutaneous BID for patients less than 45 kilograms
- Pneumatic pressure stockings
- Diuretics:
- Furosemide (Lasix) \_\_\_\_\_
  - Torsemide (Demadex) \_\_\_\_\_
  - Spironolactone (Aldactone) 25 mg daily \_\_\_\_\_
- Warfarin (Coumadin) \_\_\_\_\_
- Digoxin \_\_\_\_\_
- Nesiritide (Natrecor) administer according to standing protocol
- Calcium Channel Blockers: Choose One
- Amlodipine (Norvasc) \_\_\_\_\_
  - Other \_\_\_\_\_
- Nitrates: Choose one
- Intravenous Nitroglycerin \_\_\_\_\_
  - Isosorbide mononitrate (Imdur) \_\_\_\_\_
  - Isosorbide dinitrate (Isordil) \_\_\_\_\_
  - Other \_\_\_\_\_
- PRN medications
- Nitroglycerin 0.4 mg sublingually for chest pain; repeat every 5 minutes X 2 doses PRN and notify MD
  - Acetaminophen (Tylenol) 650 mg every 4 hours by mouth as needed for headache
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_

**Education**

- Smoking cessation counseling
- Pt to receive heart failure education sheets prior to discharge
- Palliative Care Team referral for AHA class IV
- Cardiac rehabilitation referral
- Case management referral for Home health care
- Dietician referral
- Other \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Time** \_\_\_\_\_

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