DIAGNOSIS	DRUG ALLERGIES

DATE/ TIME	CONGESTIVE HEART FAILURE DISCHARGE ORDERS Page 1 of 1
	☐ **These orders can be checked by the physician to designate further instructions.** ☑ **These orders will be followed unless crossed out.**
	1. ☐ Discharge to home
	2. ☐ Referral to: ☐ Home Health/Community Case Management ☐ Infusion Clinic _____ ☑ Nurse Practitioner
	3. ☐ Patient's ejection fraction is _____ %.
	4. Schedule follow-up: Dr._____ in _____ weeks Dr._____ in _____ weeks ☐ EF less than 40% - schedule patient for follow-up echocardiogram in _____ (time frame)
	5. Discharge Instructions: ☐ Restrict fluids to about _____ cups/day. ☐ Smoking cessation ☐ Heart Healthy Eating Class – **Patients** to call (740) 383-8484 to schedule appointment. ☐ Sudden Cardiac Arrest DVD and education
	6. ☐ **For LVSD:** ACEI:_____ or ARB:_____ If not ordered, indicate contraindication: ☐ ACEI allergy ***- Quality Indicator*** ☐ ARB allergy ☐ Known adverse reaction ☐ Hypotension ☐ Aortic stenosis, moderate/severe ☐ Renal insufficiency ☐ Cough ☐ Other:_____
	7. Betablocker:_____ (if SBP less than 100 or HR less than 60, Nursing to call for lower dose) If not ordered, indicate contraindication: ☐ Allergy ☐ Heart rate less than 60 ☐ SBP less than 90 ☐ Cardiogenic Shock ☐ 2nd or 3rd degree heart block in ECG ☐ Other:_____
	8. ☑ Refer to Discharge Medication Reconciliation Orders
	Date:_____ Physician Signature:_____

PATIENT LABEL

Marion General Hospital
OhioHealth

CONGESTIVE HEART FAILURE DISCHARGE ORDERS

PLEASE WRITE LEGIBLY

Formulated: 10/04
Reviewed:
Revised: 6/05,10/08