

Southwest General Hospital Standing Admission Orders Heart Failure

Attending Physician: _____ **Date:** _____ **Time:** _____
Admit to Inpatient: Med/Surg Telemetry MICU SICU
Place in Observation Services: Med/Surg Telemetry Other _____
Diagnosis: New Onset Heart Failure Acute Exacerbation Heart Failure Other: _____
Condition: Stable Guarded Critical Good Fair Poor
Consult: Cardiology: _____ Pulmonary: _____
 Other: _____
Allergies: _____

Code Status: Full DNR

Vital Signs: Per unit protocol Every shift Every _____ hours
 Call for SBP more than _____ SBP less than _____ DBP more than _____ DBP less than _____
 Other: _____

Activity: Bed rest Up in chair Bedside commode Ambulate ad lib Bathroom privileges only

Nursing: Daily weight Intake & Output Foley to drainage Sequential Compression Device (SCD)
 Pulse oximeter on admission
 Glucose checks AC and qHS or every _____ hrs Fluid restriction: _____ ml/days
 Other: _____

Diet: Regular NPO 2 gm low sodium Clear liquid Full liquid Cardiac
 Carbohydrate controlled No Caffeine 1800 calorie 2000 calorie 2200 calorie
 Other: _____

Fluids: Intravenous: _____ @ _____ ml/hr
 Saline lock
 Other: _____

Oxygen: Nasal Cannula _____ L/min, adjust to keep O2 sat more than 92%
 Venti Mask _____ % FIO2 100% NRB
 Other: _____



Protocols (if available): All protocol orders must be placed in chart
 Weight Based Heparin Dosing Protocol (when patient placed on protocol, all associated labs and monitoring is included)
 Insulin Infusion Protocol (Glucommander) (ER, IMC, ICU patients only)


Labs: Troponin T Myoglobin BMP CMP ProBNP D-Dimer
 Phosphorus Fasting lipid profile TSH UA CBC
 ABG Digoxin level Magnesium
 Other Labs: _____

Studies: CXray: () Portable () PA/Lateral
 EKG now and in AM STAT EKG PRN with chest pain or palpitations ECHOCARDIOGRAM
 DR _____ TO READ
 Nuclear Cardiac Scan (assess wall motion, EF)
 Other: _____

CORE MEASURE: IF LVSD NOT ASSESSED THIS HOSPITALIZATION, DOCUMENT PRIOR EF OR REASON TEST NOT PERFORMED:

Physician Signature: _____
Date/Time: _____

 	Account Number:	MR Number:
	Patient Name:	
	Admit Date:	

 <p>7400 Barlite Blvd. San Antonio, TX 78224 (210) 921-2000</p>	DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
	Allergies:								
	Attending Physician Name:								

