



**PHYSICIAN'S ORDERS**

**ALLERGIES: See Master Allergy Sheet**

ORDERED		HEART FAILURE ORDERS	TIME ORDER NOTED
Date	Time		
		Check appropriate boxes:.	
		<b>Primary Diagnosis:</b>	
		<b>Ejection Fraction:</b> _____% as of echo dated ___/___/___ (within past 12 months)	
		(unit clerk obtain and place copy of previous echocardiogram report on current inpatient record)	
		<b>Ejection Fraction Unknown or &gt; 12 months</b>	
		<input type="checkbox"/> Echocardiogram (indication "CHF" to be read per call rotation, or read by Dr. _____)	
		<input type="checkbox"/> Schedule Echo in my office. Date: _____	
		<input type="checkbox"/> <b>ACEI/ARB:</b> complete with dose/frequency/route	
		<input type="checkbox"/> Lisinopril (Prinivil)	
		<input type="checkbox"/> Ramipril (Altace)	
		<input type="checkbox"/> Other:	
		OR	
		<input type="checkbox"/> <b>Losartan (Cozaar)</b>	
		<input type="checkbox"/> Valsartan (Diovan)	
		<input type="checkbox"/> Other:	
		<input type="checkbox"/> <b>ACEI/ARB not ordered</b> because (circle): allergy / renal artery stenosis /	
		Angioedema / Hyperkalemia / mod or severe aortic stenosis / Hypotension /	
		Worsening renal functions/renal disease/dysfunction / patient refused /	
		Other:	
		Complete Heart Failure Discharge Instructions (Form 18-201.26)	
		Physician Signature:	Date/Time:

▼ Addressograph / Patient Label ▼



**HEART FAILURE ORDERS**