Methodist Healthcare

(Place Patient Identification here)

Heart Failure Discharge Prescription Orders

Please use ballpoint pen.

Home Medications	Resume	Home Medications	Resume
_____ Dose _____	[ ] Yes [ ] No	_____ Dose _____	[ ] Yes [ ] No
_____ Dose _____	[ ] Yes [ ] No	_____ Dose _____	[ ] Yes [ ] No
_____ Dose _____	[ ] Yes [ ] No	_____ Dose _____	[ ] Yes [ ] No
_____ Dose _____	[ ] Yes [ ] No	_____ Dose _____	[ ] Yes [ ] No

****CMS recommends an ACEI or ARB for patients with LVEF < 40%. Please document reason if not prescribing either one.**

Label with strength and name of each drug for ALL ordered medications. **Patient Weight: _____ (KG)**

ACE Inhibitor OR ARB **MEDICATION** **DOSAGE FORM** **STRENGTH**

SIG: _____
ACEI Contraindicated because: _____
ARB Contraindicated because: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

Beta Blocker **MEDICATION** **DOSAGE FORM** **STRENGTH**

SIG: _____
Contraindicated because: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

Aldosterone antagonist **MEDICATION** **DOSAGE FORM** **STRENGTH**

SIG: _____
Contraindicated because: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

Diuretic **MEDICATION** **DOSAGE FORM** **STRENGTH**

SIG: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

MEDICATION **DOSAGE FORM** **STRENGTH**

SIG: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

MEDICATION **DOSAGE FORM** **STRENGTH**

SIG: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

MEDICATION **DOSAGE FORM** **STRENGTH**

SIG: _____

Qty# _____
QTY Spelled Out: _____
Refill x _____ [ ] No substitute

_____ _____ **DATE:** _____ **DEA NO:** _____

signature **name printed**

ENTERED	
FILLED	