vitalcare® of the FOUR STATES

MILRINONE ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☑ **Milrinone 40mg/D5W 200 ml IV (200mcg/ml)** **REFILLS: _____**

☑ Infuse _____ mcg/kg/min

Infusion Pump: _____

DISPENSE: 10 bags at a time

☐ **LABS** **REFILLS: _____**

☐ OTHER: _____

☐ LABS: _____

☐ **DRESSING CHANGES WEEKLY PER VITAL CARE OF THE FOUR STATES**

☐ **DRESSING CHANGES WEEKLY PER _____HOME HEALTH**

IV / ACCESS / MAINTENANCE:

☐ CENTRAL LINE - Flush with Normal Saline 10 ml before each bag of medication.

☐ PICC - Flush with Normal Saline 10 ml before each bag of medication. (Left arm / DL)

☐ Subcutaneous Port - Flush with Normal Saline 10 ml before each bag of medication.

DIAGNOSIS:

☐ I50.22 Congestive Heart failure

☐ _____