Home Parenteral Inotropic Therapy: Data Collection Form

Patient's Name:_____ HIC #:_____

Information below may not be completed by the supplier nor anyone in a financial relationship with the supplier.

1) Results of invasive hemodynamic monitoring:

	Cardiac index	**Wedge Pressure**	**Date**
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____

Drug_____ Dose _____ mcg/kg/min

2) Cardiac drugs (digoxin, diuretics, vasodilators) immediately prior to inotrope infusion (list name, dose, frequency): _____

3) Does this represent maximum tolerated doses of these drugs?

4)

Breathing status (check one in each column):	**Prior to inotrope infusion**	**At time of discharge**
No dyspnea on exertion	_____	_____
Dyspnea on moderate exertion	_____	_____
Dyspnea on mild exertion	_____	_____
Dyspnea at rest	_____	_____

5) Initial home prescription: Drug _____ _____ mcg/kg/min

_____ hrs/day _____ day/week (or every _____days)

6) If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? _____

7) If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required? _____

8) Is the patient capable of going to the physician for outpatient evaluation: _____

9) Is routine electrocardiographic monitoring required in the home? _____

The above statements and any additional explanations included separately are true and accurate and there is documentation present in the patient's medical record to support these statements.

Physician Signature:_____ Date: _____

Physician Name Printed/Typed: _____ UPIN #: _____

Physician Specialty: _____