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:

<table>
<thead>
<tr>
<th>Cardiac index</th>
<th>Wedge Pressure</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before inotrope infusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On inotrope infusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Dose mcg/kg/min</td>
<td></td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Prior to inotrope infusion</th>
<th>At time of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dyspnea on exertion</td>
<td></td>
</tr>
<tr>
<td>Dyspnea on moderate exertion</td>
<td></td>
</tr>
<tr>
<td>Dyspnea on mild exertion</td>
<td></td>
</tr>
<tr>
<td>Dyspnea at rest</td>
<td></td>
</tr>
</tbody>
</table>

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: _______________________________