



# Home Parenteral Inotropic Therapy: Data Collection Form



Patient's Name: \_\_\_\_\_ HIC#: \_\_\_\_\_

Neither the supplier nor anyone in a financial relationship with the supplier may complete the information below.

1) Results of invasive hemodynamic monitoring or impedance cardiography:

	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, does, frequency): \_\_\_\_\_

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

4) Breathing status (check 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 \_\_\_\_\_ days/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 evaluations: \_\_\_\_\_

9) Is the 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: \_\_\_\_\_