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Heart Failure Discharge Initiative Discharge Sheet

Date _____ Time _____ Primary Care Physician _____ Cardiologist _____

Primary reason for hospitalization ☐ Low cardiac output ☐ Hypervolemia ☐ Pneumonia ☐ Atrial fibrillation/tachycardia

☐ Ventricular dysrhythmia ☐ Chest pain / AMI / R/O MI ☐ Infection ☐ Bleeding ☐ Other _____

Admission labs Na^+ _____ K^+_____ Creatinine _____ GFR _____ BNP_____ NT-proBNP _____

Discharge labs Na^+ _____ K^+_____ Creatinine _____ GFR _____ BNP_____ NT-proBNP _____

Discharge condition NYHA Class _____ Admissions weight _____ Discharge weight _____ Target weight _____

Primary signs/symptoms when decompensated ☐ Dyspnea at rest ☐ Extreme fatigue ☐ Ascites ☐ Leg edema

☐ Dizziness ☐ Low BP ☐ High BP ☐ Other _____

Activity ☐ Be active; walk 20 min/day ☐ Same as pre-hospitalization ☐ Cardiac rehabilitation in 6 weeks

Discharge location ☐ Home ☐ Home with home health ☐ Skilled Nursing Facility ☐ Rehab

☐ Other _____

Discharge diet ☐ Low-sodium _____ mg/day ☐ Fluid restriction _____ mL/day ☐ CMC Heart Diet

☐ Diabetic diet _____ calories ☐ Other_____

☐ Instructions given ☐ Patient verbalizes understanding

In-hospital treatments ☐ IV diuresis ☐ New medications; describe _____

☐ Decreased dose of medications; describe _____

☐ Increased dose of medications; describe _____

☐ New medications; describe _____

☐ New diagnosis; describe _____

Labs Date(s) to be drawn _____

☐ BNP ☐ NT-proBNP ☐ Troponin I ☐ PT/INR ☐ PTT ☐ Basic metabolic profile ☐ Lipid level

☐ CBC ☐ Digoxin level ☐ Other _____

Medications reviewed and reconciled ☐ Yes ☐ No ☐ Patient understands changes

Education provided ☐ Diet ☐ Activity ☐ Medications ☐ Signs/symptoms of worsening condition ☐ Follow-up appointment

☐ Follow-up patient education recommended ☐ Instruct to discard all other home medications ☐ Care coordinator assigned

Follow up Patient record release form signed ☐ Yes ☐ No

Cardiologist	_____	Date	_____	Phone	_____
Primary Care	_____	Date	_____	Phone	_____
Cardiac Rehab	_____	Date	_____	Phone	_____
Nephrologist	_____	Date	_____	Phone	_____
Pulmonary	_____	Date	_____	Phone	_____
Other	_____	Date	_____	Phone	_____
MD/PA/ANP signature	_____	Date	_____	Time	_____
MD/PA/ANP signature	_____	Date	_____	Time	_____

Logo, Rev #, Sheet barcode

Patient information barcode