Heart Failure Discharge Information

☐ **I understand that I have been treated in the hospital for heart failure**

Tests Results: Ejection Fraction _______ % Description___________________________

Medications. I understand that medications including ACE inhibitors and beta blockers may help me to prevent a future heart attack and help me live a longer and healthier life.

☐ I have received instructions on my discharge medications.

☐ No instructions because ____

	Prescribed	Not prescribed because
ACE Inhibitor:	☐ _________________	☐ _____________________________
Beta Blocker:	☐ _________________	☐ _____________________________

Physician Signature ____________________Date_________________

Smoking. I understand that smoking increases my chances of having a heart attack, can affect the quality of my life and shorten my life. ☐ I do not smoke

☐ I smoke and have been counseled to stop. No counseling because________________________

Diet. I understand that a low salt diet is recommended for patients with heart failure to prevent shortness of breath and swelling of feet and ankles.

☐ I received counseling about a low fat diet. ☐ No diet instruction because __________________

Exercise

☐ My activity instructions until I see my provider _______________________________________

☐ No activity instructions provided because ____

Education

☐ I received heart failure education in the hospital. ☐ No education because__________________

What to do if my condition changes

☐ I understand that I should call 911 for heart pain or chest discomfort not relieved by nitroglycerin or lasting more than 20 minutes and that I should call my doctor's office for other changes in my condition. ☐ Instructions not provided because ______________________________________

Daily weights

☐ I have received instructions about recording daily weights.

☐ Instruction not provided because ____

Follow-up: I have been advised to see_______________________on________________________

Telephone _______________

Patient signature: _________________ Date______ Nurse signature: _____________ Date_______

Adapted from a tool developed by the ACCF AMI GAP Project

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