

Sample Heart Failure Clinic Visit Template

Name: _____ Date: _____ Physician: _____	ACCF Stage A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> NYHA Class I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> EF _____% Date _____ Systolic dysfunction <input type="checkbox"/> Diastolic dysfunction <input type="checkbox"/> Valvular <input type="checkbox"/>
ICD Codes: _____	CPT Codes: _____
Visit Duration: _____ minutes	

Nurse Assessment	
Chief Complaint: _____	
Wt: _____ change? _____ time interval _____ BP sitting _____ standing _____ Smoking status _____ packs per day _____ Sleeping: (Check one) <input type="checkbox"/> Well <input type="checkbox"/> Fair <input type="checkbox"/> Poor Pneumovax given? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Flu shot? <input type="checkbox"/> Not due or already given <input type="checkbox"/> Due <input type="checkbox"/> Given _____	Symptoms and Physical Findings <input type="checkbox"/> Cough <input type="checkbox"/> Orthopnea <input type="checkbox"/> Palpitations <input type="checkbox"/> _____ <input type="checkbox"/> Chest pain _____ <input type="checkbox"/> Paroxysmal nocturnal dyspnea <input type="checkbox"/> Abdominal complaints _____ Cardiac rhythm _____ JVP _____ Lungs <input type="checkbox"/> Rales _____ Other <input type="checkbox"/> Ascites <input type="checkbox"/> Distal edema _____

Comorbidities: Diabetes Hyperlipidemia Hypertension Atrial fibrillation Renal Insuff

Drugs: ACC Class I for LVSD				
	Drug	Dose	Frequency	If not, why?
	ACE Inhibitor _____			
	HF Beta Blocker _____ <small>(bisoprolol, carvedilol, metoprolol)</small>			
	Warfarin for A fib _____			
	Other medications	Drug	Dose	Frequency
	Diuretic(s) _____			
	Sliding Scale diuretic _____			
	Aldosterone antagonist _____			
	ARB _____			
	Aspirin _____			
	Statin _____			
	Other _____			
	Other _____			
	Other _____			
	Other _____			
Medications Changed? _____ Samples? _____				

Notes	Plan (Check all that apply) <input type="checkbox"/> Echo _____ <input type="checkbox"/> B-type NP _____ <input type="checkbox"/> BMP/Chem _____ <input type="checkbox"/> CBC _____ <input type="checkbox"/> INR _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ : <input type="checkbox"/> _____ Next appointment _____ <input type="checkbox"/> weeks/ mos.
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Heart Failure Education
 General Daily Weight Smoking cessation Medications Diet _____ Activity

Activity recommendation _____

Self Management Goal: _____
(Patient to set goal at the end of each visit)

Other instructions _____

Physician signature _____ **Date** _____