TARGET:HF[SM]

GENERAL INFORMATION

Discharge date: (mm/dd/yyyy)		
Patient name:		
Date of birth: (mm/dd/yyyy)		
Primary care physician:		
Cardiologist:		
Homecare?	☐ YES ☐ NO	Assisted Care? ☐ YES ☐ NO
Labs ordered/done prior to first follow-up call or appointment?	☐ YES ☐ NO	
	Date: (mm/dd/yyyy)	

PATIENT EDUCATION

INTRODUCTION: My name is _____. I am calling from [INSERT HOSPITAL NAME]. I am doing a follow-up courtesy call to see how you are doing.

Weight monitoring	
Do you have a scale at home that you can use to weight yourself?	☐ YES ☐ NO If no: Comments_____
[*If patient answered no, advise the patient to buy a scale]*	☐ YES ☐ NO
[*If patient answered yes to having a scale]* Can you see the numbers on the scale?	☐ YES ☐ NO
Have you been weighing yourself daily?	☐ YES ☐ NO
Dry weight (at home, 1st day after discharge)	
Did you take your dry weight 1 day after discharge?	☐ YES ☐ NO
Do you have a weight diary?	☐ YES ☐ NO
	If no, was the patient provided with a weight calendar during this visit? ☐ YES ☐ NO
Do you understand how and when to check your weight? *[Tell patient that he/she should check weight every AM, after first void, prior to PO intake; with same amount of clothing on]*	☐ YES ☐ NO
Do you understand the important of measuring and recording your daily weights? *[Tell patient that daily weights are important to self-monitor for fluid retention]*	☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:

Fluid restriction (if applicable to this patient)	
Do you know why it is important to restrict your fluid intake?	☐ YES ☐ NO
How many liters/cups of fluid do you consume a day? *[Tell patient that he/she should keep fluid intake to less than 2 L/day of fluid to lessen fluid overload and improve breathing.]*	☐ 1.5 L ☐ 6 cups ☐ 2.0 L ☐ 8 cups ☐ N/A ☐ N/A
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Low-sodium diet	
Are you following a low-sodium diet? If yes, what is your sodium limit per day?	☐ YES ☐ NO (reason): _____
Review low-sodium diet expectation in relation to patient's individual scenario (i.e., eats out, likes ethnic foods, is thirsty, uses salt when cooking, reads labels, someone else cooks, etc). *[Discuss "Salty Six food group]*	☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Exercise/Physical Activity	
Are you engaging in daily physical activity? Are you engaged in any exercise?	☐ YES ☐ NO (reason): ☐ YES ☐ NO (reason):
Review importance of physical activity and exercise	☐ YES ☐ NO
Habits	
Are you currently a smoker? *[A smoker is defined as someone who has smoked any time in the past year]*	☐ YES ☐ NO
[If patient answers yes] Did you provide the patient with smoking-cessation counseling?	☐ YES ☐ NO
Do you consume alcohol? *[Patients with heart failure should be advised not to consume alcohol]*	☐ YES ☐ NO Counseling ordered: ☐ YES ☐ NO
Do you take any illicit drugs? *[If yes, patients should be advised to stop using illicit drugs]*	☐ YES ☐ NO Counseling ordered: ☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:

Signs and symptoms	
List the ways you know your heart failure is getting worse? If the signs or symptoms (above) get worse, what will you do? Whom will you call? *[Discuss practical ways to determine worsening symptoms]*	Factors (list): _____
[Review with patient the contact information for whom to call in case they experience signs of symptoms of heart failure]	PCP name: Phone number: Cardiologist: Phone number: APN/PA: Phone number:
Weight/swelling	
Do you know what to do if you gain more than 4 pounds from your dry weight? *[Tell the patient that he/she should contact his/her physician if he/she gains excessive weight]*	☐ YES ☐ NO
Do you know what to do if you notice more swelling in the feet, ankles, or stomach region? Or if you wake up suddenly from a sound sleep or are urinating at night (more than previously)? *[Tell the patient that he/she should contact his/her physician if he/she gains excessive weight]*	☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Breathing	
Have you experienced worsening in shortness of breath?	☐ YES ☐ NO If yes, when?:_____
[Review with patient what to do if they experience: *-More shortness of breath than usual* *-Difficulty breathing when lying down* *-A dry hacking cough]*	☐ Review provided
Have you experienced worsening in shortness of breath?	☐ YES ☐ NO If yes, when?:_____
Other symptoms	
[Review with patient what to do if they are feeling more tired/have less energy, have a poor appetite/or early satiety, or are feeling uneasy; or "something is not right"]	☐ Completed
Patient should go to the emergency room/call 911 if:	
[Explain to patient that they should go to emergency room or call 911 if they experience any of the below symptoms: *-Struggle to breathe or have unrelieved shortness of breath at rest*	☐ Completed

-New or worsening chest pain or chest pain that is not reduced with 1 dose of nitroglycerine *-New or worsening confusion or having trouble thinking clearly* *-Persistent palpitations (racing heart)* *-Lightheadedness that does not quick resolve* *-Passing out]*	
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:

Medications for Heart Failure Management

Medication Reconciliation Completed ☐	Comments:
Can you afford to buy your medications?	☐ YES ☐ NO (reason):_____
Have you filled your prescription(s) as ordered?	☐ YES ☐ NO (reason):_____
Do you have a prescription drug plan?	☐ YES ☐ NO (reason):_____
Diuretic **(if applicable to this patient)**	
Are you taking a diuretic (water pill)?	☐ YES ☐ NO ☐ UNSURE
[Provide patient education regarding the use/indication for this drug: water pill to remove excess water from legs, feet, lungs, and stomach]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to diuretic
If patient is not on diuretics, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
ACE-inhibitor, angiotensin receptor blocker or angiotensin receptor neprilysin inhibitor if patient has reduced LVEF (LVEF <40%) **(if applicable to this patient)**	
Are you taking an ACEI, ARB, or ARNI?	☐ YES ☐ NO *[If YES to ARNI, ensure that patient is NOT also taking an ACEI or ARB]*
[Provide the patient with education on how ACEI, ARB, or ARNI can serve to relax blood vessels, making it easier for heart to pump]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to ACEI, ARB, or ARNI
If patient is not on ACEI, ARB, or ARNI, indicate why (contradictions).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Beta-blocker if patient has reduced LVEF (LVEF<40%) **(if applicable to this patient)**	

Are you taking a beta blocker? *[If patient has reduced LVEF (EF<40%), preferred evidenced-based data beta blockers are carvedilol, metoprolol succinate (XL) and bisoprolol)*	☐ YES ☐ NO
[Provide the patient with education on how a beta blocker can help the heart pump better over time, and can block the body's response to certain substances that damage heart muscle	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to beta blocker
If patient is not on a beta blocker, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Aldosterone antagonist if patient has reduced LVEF (LVEF<40%) (if applicable to this patient)	
Are you taking an aldosterone antagonist? *[If patient has reduced LVEF (EF<40%),need to closely monitor K and Cr]*	☐ YES ☐ NO
[Provide the patient with education on how an aldosterone antagonist helps to block sodium and water reabsorption, helps prevent further damage to heart, and that at low doses (6.25-25mg/day) is not used as a water pill.]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to aldosterone antagonist
If patient is not on an aldosterone antagonist, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Hydralazine/nitrate for African American patients with reduced LVEF (LVEF<40%) (if applicable to this patient)	
Are you taking hydralazine/nitrate? *[If patient has reduced LVEF (EF<40%), and is of black race]*	☐ YES ☐ NO
[Provide the patient with education on how hydralazine/nitrate can help open up the vessels of the heart, and makes it easier for the heart to pump.]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to hydralazine/nitrate
If patient is not on hydralazine/nitrate, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Warfarin or other anticoagulant (if indicated for patients with chronic/recurrent AFib or mechanical valve)	
Are you taking warfarin or other oral anticoagulant?	☐ YES ☐ NO
[Provide the patient with education on how warfarin or other anticoagulants can help to prevent stroke by serving as a blood thinner.]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to warfarin or other anticoagulant

If patient is not on warfarin or other anticoagulant, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Potassium/magnesium supplements (if applicable to this patient)	
Are you taking potassium/magnesium supplements?	☐ YES ☐ NO
[Provide the patient with education on how warfarin or other anticoagulants can help to prevent stroke by serving as a blood thinner.]	☐ Patient education provided ☐ Patient education not provided due to medical contraindications to potassium/magnesium supplements
If patient is not on potassium/magnesium supplements, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Lipid-lowering medication if patient has cardiovascular disease (CVD), peripheral vascular disease (PVD), or cerebrovascular accident (CVA) (if applicable to this patient)	
Are you taking lipid-lowering medications?	☐ YES ☐ NO
If patient is not on lipid-lowering medications, indicate why (contraindications).	Patient had side effects that include:
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Omega 3 fatty acid supplementation (if applicable to this patient)	
Are you taking omega 3 fatty acids?	☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Diuretic self-management	
Is the patient an appropriate candidate for diuretic self-management?	☐ YES ☐ NO
[Review when it is appropriate to take extra diuretics +/- potassium based on weight gain and other symptoms]	☐ YES ☐ NO
[If weight gain persists > 2 days, advise the patient to call provider]	☐ YES ☐ NO
Confirmed understanding by Teach Back? *[The patient or family member can verbalize your instructions back to you in their own words to confirm understanding.]*	☐ Yes ☐ Patient needs reinforcement Comments:
Other questions	
Have you scheduled a follow-up appointment?	☐ YES ☐ NO Comments:_____

Do you have transportation to and from the hospital?	☐ YES ☐ NO Comments:_____
Do you have any other questions related to:	☐ Diet ☐ Activity ☐ Medications ☐ Other concerns (list):_____

GENERAL INFORMATION

General comments:			
Further action needed post follow-up call?		☐ YES ☐ NO	
If yes, what follow-up action is needed/performed?	☐ Notify doctor	Name:	
		Number:	
		Date:	
		Time:	
		☐ Call in prescriptions to pharmacy	Pharmacy name: Pharmacy phone number:
		☐ Call patient regarding _____	
	Set up appointment with doctor	Doctor name:	
	Call in [ ] days for:		
	Other:		
Telephone:	Person interviewed:	☐ Patient ☐ Other (name/relation): _____	

Attempts to contact:

Date:	**Time:**	**Initials:**
Date:	**Time:**	**Initials:**
Date:	**Time:**	**Initials:**
RN name (print):		
RN signature:		
Date:	**Time:**	

TEMPLATE TELEPHONE FOLLOW-UP INTERVIEWER INSTRUCTIONS

COMPLETE FOLLOW-UP FORM (See below).

ITEMS REQUIRING FURTHER INTERVENTION:

CONTACT PROVIDER FOR:

01 Unfilled prescriptions
02 Questions on medications

CONTACT SCHEDULER FOR:

01 Follow-up appointment

CONTACT NURSE FOR:

01 Questions on diet, activity, weight monitoring
02 Further evaluation of worsening symptoms
03 Follow-up on weight monitoring