Do not take other or additional medications at home without checking with your physician.
Remember to take this sheet to your next doctor's appointment.

### MEDICATIONS

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY/indicate times to be taken</th>
<th>NEXT DOSE DUE</th>
<th>SPECIAL INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOR CARDIOVASCULAR PATIENTS</td>
<td></td>
<td>REMEMBER CORE MEASURES *</td>
<td></td>
<td>(i.e. Food/Drug Interactions)</td>
</tr>
<tr>
<td>☐ ASPIRIN *</td>
<td></td>
<td>mg Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ PLAVIX</td>
<td>75 mg</td>
<td>Daily</td>
<td></td>
<td></td>
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<tr>
<td>☐ ACEI *</td>
<td></td>
<td></td>
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<tr>
<td>☐ ARB *</td>
<td></td>
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<tr>
<td>☐ BETA BLOCKER *</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>☐ STATIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER MEDICATIONS</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**SOME MEDICATIONS MAY HAVE FOOD INTERACTIONS. READ WRITTEN MATERIAL PROVIDED AND ASK YOUR DOCTOR & PHARMACIST.**

### SPECIAL INSTRUCTIONS

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### FOLLOW-UP

Call for a follow-up appointment

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### COMMUNITY RESOURCES / REFERRALS

WEEKLY SMOKERS SUPPORT GROUP 845-483-6470
SMOKERS HOT LINE: 1-866-697-8487
WWW.CDC.GOV/TOBACCO
☐ WOUND CARE CENTER 845-431-2400
☐ CARDIAC REHAB
   (For unstable angina, heart attack, Coronary bypass)
☐ OTHER
☐ IF YOU NEED INFORMATION ON COMMUNITY RESOURCES
   CALL VBM CASE MANAGEMENT: 845-437-3101

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### IMMUNIZATIONS

☐ Assessment/Education done
☐ NA
☐ Pneumococcal, Date:
☐ Influenza, Date:

---

May we contact you after discharge? ☐ Yes ☐ No
At what number may we reach you?
What is the preferred time to call?

---

M.D.

R.N.

SIGNATURE OF PATIENT OR RESPONSIBLE OTHER

☐ I have reviewed and assessed that the patient and/or family understand the information on this document
HEART HEALTH
- Daily Weight Monitoring: Record your weight daily in a notebook. Call MD if weight gain of 2-3 lbs. or more per day over 2 days.
- Your Diet: Avoid salt and eat foods low in sodium, low in fat. Read all labels. Follow the diet prescribed by your MD.
- Medications: Keep a list of your current medications. Use a medication organizer to keep track of your medication. Take medication as instructed. Bring medications to MD office.
- Activity as Tolerated: Exercise as instructed by your MD.

INCISION / WOUND CARE
- Wash your incision / wound with soap and water in the Tub, Shower.
- Dressing care per MD / RN.
- You have steri-strips on your incision which will fall off by themselves. You can wash over them gently, and if they fall off, leave them off.
- It is normal to have soreness in and around your incision/wound which may increase as you become more active as compared to when you are resting.
- Keep pressure off wound. Turn and re-position at least every 2 hours.

CALL YOUR DOCTOR IF ANY OF THESE OCCUR
- Weight gain greater than 2-3 lbs. or more periodically over 2 days.
- Shortness of breath
- Swelling of your ankles or legs
- Persistent cough
- Chest pain
- If you have more redness or drainage from your incision
- If you have nausea and vomiting that does not go away in 24 hours
- If any symptoms worsen
- If you develop a fever (temperature over 100°F or 38°C)
- If you have more pain in the area of your incision

HOME HEALTH INFORMATION REFERRAL REQUEST IF APPLICABLE

REFERRAL TO: __________ PHONE # _____________ AGENCY NOTIFIED
FAX PATIENT FACE SHEET AND THIS REFERRAL TO:
FAX # ___________

CONTACT PERSON # ___________ AND VISIT @
SERVICE REQUESTED: □ Skilled nursing □ HHA □ PT □ OT □ Speech □ MSW □ Other
DIAGNOSIS: ___________________________ SURGERY: ___________________________
SURGERY DATE: ________________________

SKILLED NURSING NEED i.e. teaching, review meds, monitoring wt compliance issues

TREATMENT PLAN: i.e. Wound care, pressure ulcer prevention

ALLERGIES: _____________________________
ACTIVITIES: ____________________________

VITAL SIGNS: BP __________ Pulse __________ Hgb _________
TEMP _________ HT __________ WT __________ Hct _______

MEDICAL SUPPLIES
□ Walker □ Oxygen device/flow _____________
□ Wheelchair □ Other _____________
□ Hospital bed □ Heel Lift □ R □ L □ Commode

TRANSFER INFORMATION (SNF, INPATIENT REHAB, ASSISTED/ADULT HOME)

TRANSFER TO: (name) ___________ (phone) ___________
VITAL SIGNS: BP __________ Pulse __________ Hgb _________ BUN _________
TEMP _________ HT __________ WT __________ Hct _______ CR _________

Comments:

NOTE: TRANSFER TO ACUTE CARE MUST USE INTERAGENCY FORM

I have been informed of area home health care agencies and understand that Hudson Valley Home Care is an affiliate of VBMC

[Signature]

M.D.

REVIEW AND INITIAL

[Signature]

R.N.

INITIAL OF PATIENT OR RESPONSIBLE OTHER

[Signature]

MD-361A (rev. 3/05) #1634 CHART