

FORM SELECTION

Legend: Elements in bold are required

Heart Failure		Patient ID:	
DEMOGRAPHICS TAB			
Demographics			
Sex	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Patient Gender Identity	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="radio"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="radio"/> Genderqueer, neither exclusively male nor female <input type="radio"/> Additional gender category or other. _____ <input type="radio"/> Did not disclose.		
Patient-Identified Sexual Orientation	<input type="radio"/> Straight or heterosexual <input type="radio"/> Lesbian or gay <input type="radio"/> Queer, pansexual, and/or questioning <input type="radio"/> Something else; please specify. _____ <input type="radio"/> Don't know <input type="radio"/> Declined to answer		
Date of Birth	___/___/___ (MM/DD/YYYY)	Patient Postal Code	_____ - _____
Payment Source	<input type="checkbox"/> Medicare Title 18 <input type="checkbox"/> Medicaid Title 19 <input type="checkbox"/> Medicare – Private/HMO/PPO/Other <input type="checkbox"/> Medicaid – Private/HMO/PPO/Other <input type="checkbox"/> Private/HMO/PPO/Other <input type="checkbox"/> VA/CHAMPVA/Tricare <input type="checkbox"/> Self-pay/No Insurance <input type="checkbox"/> Other/Not Documented/UTD		
External Tracking ID	_____		
Race and Ethnicity			
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> UTD	
Hispanic Ethnicity	<input type="radio"/> Yes	<input type="radio"/> No/UTD	
Select Hispanic Origin Group(s):	<input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino, or Spanish Origin		
ADMISSIONS TAB			
Arrival and Admission			
Internal Tracking ID	_____	Physician/Provider NPI	_____
Arrival Date/Time	___/___/___ __:___	Admission Date	___/___/___
Transferred in (from another ED?)	<input type="radio"/> Yes		<input type="radio"/> No
Point of Origin for Admission or Visit	<input type="radio"/> 1. Non-Healthcare Facility Point of Origin <input type="radio"/> 2. Clinic	<input type="radio"/> 6. Transfer from another Health Care Facility <input type="radio"/> 7. Emergency Room <input type="radio"/> 9. Information not available	

	<input type="radio"/> 4. Transfer from a Hospital (Different Facility) <input type="radio"/> 5. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	<input type="radio"/> F. Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
Discharge Date/Time	___/___/___ : ___	
Medical History		
Medical History (Select all that apply):		
<input type="checkbox"/> Anemia <input type="checkbox"/> Atrial Fib (chronic or recurrent) <input type="checkbox"/> Atrial Flutter (chronic or recurrent) <input type="checkbox"/> ATTR-CM <input type="radio"/> Hereditary <input type="radio"/> Wild-type <input type="checkbox"/> CAD <input type="checkbox"/> CardioMEMs (implantable hemodynamic monitor) <input type="checkbox"/> COPD or Asthma <input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD) <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis (chronic) <input type="checkbox"/> Emerging Infectious Disease <input type="radio"/> MERS <input type="radio"/> SARS-COV-1 <input type="radio"/> SARS-COV-2 (COVID-19) <input type="radio"/> Other infectious respiratory pathogen <input type="checkbox"/> Familial hypercholesterolemia	<input type="checkbox"/> Heart failure <input type="checkbox"/> Heart Transplant <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> ICD only <input type="checkbox"/> Kidney Transplant <input type="checkbox"/> Left Ventricular Assist Device <input type="checkbox"/> Pacemaker <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prior CABG <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Renal insufficiency - chronic (SCr>2.0) <input type="checkbox"/> Sleep-Disordered Breathing <input type="checkbox"/> TAVR <input type="checkbox"/> TMVR <input type="checkbox"/> Tricuspid Valve procedure <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Ventricular assist device	
<input type="checkbox"/> No Medical History		
Diabetes Type:	<input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> ND	
Diabetes Duration:	<input type="radio"/> <5 years <input type="radio"/> 5 - <10 years <input type="radio"/> 10 - <20 years <input type="radio"/> >=20 years <input type="radio"/> Unknown	
Sleep-Disordered Breathing Type:	<input type="checkbox"/> Obstructive <input type="checkbox"/> Central <input type="checkbox"/> Mixed <input type="checkbox"/> Unknown/Not Documented	
Equipment used at home:	<input type="checkbox"/> O2 <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Adaptive Servo-Ventilation <input type="checkbox"/> None <input type="checkbox"/> Unknown/Not Documented	
History of cigarette smoking? (In the past 12 months)	<input type="radio"/> Yes <input type="radio"/> No	
History of vaping or e-cigarette use in the past 12 months?	<input type="radio"/> Yes <input type="radio"/> No/ND	
Heart Failure History Etiology: Check if history of:	<input type="checkbox"/> Ischemic/CAD	<input type="checkbox"/> Non-Ischemic <input type="checkbox"/> Alcohol/Other Drug <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Familial <input type="checkbox"/> Hypertensive <input type="checkbox"/> Postpartum

		<input type="checkbox"/> Viral <input type="checkbox"/> Other Etiology <input type="checkbox"/> Unknown Etiology			
Known history of HF prior to this admission?	<input type="radio"/> Yes		<input type="radio"/> No		
# of hospital admissions in past 6 mo. for HF:	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> >2	<input type="radio"/> Unknown
<input type="checkbox"/> Patient Listed for Transplant					

DIAGNOSIS		Admission Tab			
Heart Failure Diagnosis	<input type="radio"/> Heart Failure, primary diagnosis, with CAD <input type="radio"/> Heart Failure, primary diagnosis, no CAD <input type="radio"/> Heart Failure, secondary diagnosis				
Atrial Fibrillation (At presentation or during hospitalization)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="checkbox"/> Documented New Onset?		
Atrial Flutter (At presentation or during hospitalization)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="checkbox"/> Documented New Onset?		
New Diagnosis of Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented		
Basis for Diagnosis	<input type="checkbox"/> HbA1c <input type="checkbox"/> Oral Glucose Tolerance		<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Test Other		
Characterization of HF at admission or when first recognized	<input type="radio"/> Acute Pulmonary Edema <input type="radio"/> Dizziness/Syncope <input type="radio"/> Dyspnea <input type="radio"/> ICD Shock/Sustained Ventricular Arrhythmia		<input type="radio"/> Pulmonary Congestion <input type="radio"/> Volume overload/Weight Gain <input type="radio"/> Worsening fatigue <input type="radio"/> Other		
Other Conditions Contributing to HF Exacerbation <i>Select all that apply</i>	<input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pneumonia/respiratory process <input type="checkbox"/> Noncompliance - medication		<input type="checkbox"/> Worsening Renal Failure <input type="checkbox"/> Ischemia/ACS <input type="checkbox"/> Uncontrolled HTN <input type="checkbox"/> Noncompliance – Dietary <input type="checkbox"/> Other		
Active bacterial or viral infection at admission or during hospitalization	<input type="radio"/> None/ND <input type="radio"/> Bacterial infection <input type="radio"/> Emerging Infectious Disease <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> MERS <input type="checkbox"/> Other infectious respiratory pathogen <input type="radio"/> Influenza <input type="radio"/> Seasonal Cold <input type="radio"/> Other Viral Infection				
New Diagnosis of ATTR-CM	<input type="radio"/> Yes <input type="radio"/> Hereditary <input type="radio"/> Wild-Type <input type="radio"/> Unknown/Not Documented <input type="radio"/> No <input type="radio"/> Not Documented				

MEDICATIONS AT ADMISSION	Admission Tab
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Medications Used Prior to Admission: <i>[Select all that apply]</i>	
<input type="checkbox"/> Patient on no meds prior to admission <input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Angiotensin Receptor Neprilysin Inhibitor (ARNI) <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Anticoagulation Therapy <input type="radio"/> Warfarin <input type="radio"/> Direct Thrombin Inhibitor <input type="radio"/> Factor Xa Inhibitor	<input type="checkbox"/> Antiplatelet agent (excluding aspirin) <input type="checkbox"/> Aspirin <input type="checkbox"/> Beta-Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Other injectable/subcutaneous agents <input type="checkbox"/> Digoxin <input type="checkbox"/> Diuretic <input type="radio"/> Thiazide/Thiazide-like <input type="radio"/> Loop

<input type="radio"/> Other <input type="checkbox"/> Anti-hyperglycemic medications: <input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> GLP-1 receptor agonist <input type="checkbox"/> Insulin <input type="checkbox"/> Mavacamten <input type="checkbox"/> Metformin <input type="checkbox"/> Mineralocorticoid Receptor Antagonist (MRA) <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> Other Oral Agents <input type="checkbox"/> Other injectable/subcutaneous agents	<input type="checkbox"/> Hydralazine <input type="checkbox"/> Ivabradine <input type="checkbox"/> Lipid lowering agent (Any) <input type="radio"/> Statin <input type="radio"/> Other Lipid lowering agent <input type="checkbox"/> Nitrate <input type="checkbox"/> Omega-3 fatty acid supplement <input type="checkbox"/> Renin Inhibitor <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> Vericiguat <input type="checkbox"/> Other Medications Prior to Admission
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Symptoms (Closest to Admission) <i>Select all that apply</i>	<input type="radio"/> Chest Pain <input type="radio"/> Orthopnea <input type="radio"/> Palpitations	<input type="radio"/> Dyspnea at rest <input type="radio"/> Fatigue <input type="radio"/> PND	<input type="radio"/> Dyspnea on Exertion <input type="radio"/> Decreased appetite/early satiety <input type="radio"/> Dizziness/lightheadedness/syncope
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EXAMS/LABS AT ADMISSION **Admission Tab**

Height	_____ <input type="radio"/> inches <input type="radio"/> cm	<input type="radio"/> Height ND
Weight	_____ <input type="radio"/> Lbs. <input type="radio"/> Kgs.	<input type="radio"/> Weight ND
Waist Circumference	_____ <input type="radio"/> inches <input type="radio"/> cm	<input type="radio"/> Waist Circumference ND
BMI	_____ (Automatically Calculated)	
Systolic	_____	
Diastolic	_____	

BP ND

Respiratory Rate (breaths per minute)	_____		
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JVP (cm):	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	JVP Value _____
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Rales:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	Rales Value _____	<input type="radio"/> <1/3	<input type="radio"/> ≥1/3	<input type="radio"/> N/A
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Lower Extremity Edema	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	Lower Extremity Value	<input type="radio"/> Trace <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+ <input type="radio"/> N/A
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Lipids	TC: _____ mg/dL	HDL: _____ mg/dL	LDL: _____ mg/dL	TG: _____ mg/dL	<input type="checkbox"/> Lipids Not Available
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Labs (Closest to Admission)

Sodium (Na+)	_____	<input type="radio"/> mEq/L	<input type="radio"/> mmol/L	<input type="radio"/> mg/dL	<input type="checkbox"/> Not Available
Hgb	_____	<input type="radio"/> g/dL	<input type="radio"/> g/L		<input type="checkbox"/> Not Available
Albumin	_____	<input type="radio"/> g/dL	<input type="radio"/> g/L		<input type="checkbox"/> Not Available
BNP	_____	<input type="radio"/> pg/mL	<input type="radio"/> pmol/L	<input type="radio"/> ng/L	<input type="checkbox"/> Not Available
NT-proBNP	_____	<input type="radio"/> pg/mL	<input type="radio"/> ng/L		<input type="checkbox"/> Not Available
Serum Creatinine	_____	<input type="radio"/> mg/dL	<input type="radio"/> μmol/L		<input type="checkbox"/> Not Available
BUN	_____	<input type="radio"/> mg/dL	<input type="radio"/> μmol/L		<input type="checkbox"/> Not Available
Troponin (Peak)	_____ <input type="radio"/> ng/mL <input type="radio"/> ug/L	<input type="radio"/> T <input type="radio"/> I <input type="radio"/> hs-I <input type="radio"/> hs-T	<input type="radio"/> Normal <input type="radio"/> Abnormal		<input type="checkbox"/> Not Available

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Potassium (K+)	_____	<input type="radio"/> mEq/L	<input type="radio"/> mmol/L	<input type="radio"/> mg/dL	<input type="checkbox"/> Not Available
Ferritin (ng/mL)	_____				
HbA1C	_____ %	<input type="checkbox"/> Not Available			
Fasting Blood Glucose (mg/dL)	_____				<input type="checkbox"/> Not Available
EKG QRS Duration (ms)	_____				<input type="checkbox"/> Not Available
EKG QRS Morphology	<input type="radio"/> Normal <input type="radio"/> LBBB	<input type="radio"/> RBBB <input type="radio"/> NS-IVCD	<input type="radio"/> Paced <input type="radio"/> Not Available		
CLINICAL CODES					Clinical Codes Tab
ICD-10-CM Principal Diagnosis Code	_____				
ICD-10-CM Other Diagnoses Codes	1.	2.	3.		
	4.	5.	6.		
	7.	8.	9.		
	10.	11.	12.		
ICD-10-PCS Principal Procedure Code	_____	Date: __/__/____	<input type="radio"/> Date UTD		
ICD-10-PCS Other Principal Procedure Codes	1.	Date: __/__/____	<input type="radio"/> Date UTD		
	2.	Date: __/__/____	<input type="radio"/> Date UTD		
	3.	Date: __/__/____	<input type="radio"/> Date UTD		
	4.	Date: __/__/____	<input type="radio"/> Date UTD		
	5.	Date: __/__/____	<input type="radio"/> Date UTD		
IN-HOSPITAL					In-Hospital Tab
In-Hospital Care					
Procedures					
<input type="checkbox"/> No Procedures <input type="checkbox"/> Cardiac Cath/Coronary Angiography <input type="checkbox"/> CardioMEMs (implantable hemodynamic monitor) <input type="checkbox"/> Coronary Artery Bypass Graft <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only) <input type="checkbox"/> Dialysis or Ultrafiltration unspecified <input type="checkbox"/> ICD only <input type="checkbox"/> Mechanical Ventilation <input type="checkbox"/> PCI <input type="checkbox"/> Right Cardiac Catheterization <input type="checkbox"/> TMVR <input type="checkbox"/> Tricuspid Valve Procedure			<input type="checkbox"/> Atrial Fibrillation Ablation or Surgery <input type="checkbox"/> Cardiac Valve Surgery <input type="checkbox"/> Cardioversion <input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD) <input type="checkbox"/> Dialysis <input type="checkbox"/> ECMO <input type="checkbox"/> Intra-aortic Balloon Pump <input type="checkbox"/> Left Ventricular Assist Device <input type="checkbox"/> Pacemaker <input type="checkbox"/> PCI with stent <input type="checkbox"/> Stress Testing <input type="checkbox"/> TAVR <input type="checkbox"/> Transplant (Heart) <input type="checkbox"/> Ultrafiltration		
EF - Quantitative	_____ %	Obtained:	<input type="radio"/> This Admission <input type="radio"/> Within the last year <input type="radio"/> > 1 year ago		
EF - Qualitative	<input type="radio"/> Not Applicable <input type="radio"/> Normal or mild dysfunction <input type="radio"/> Qualitative moderate/severe dysfunction <input type="radio"/> Performed/results not available <input type="radio"/> Planned after discharge <input type="radio"/> Not performed	Obtained:	<input type="radio"/> This Admission <input type="radio"/> Within the last year <input type="radio"/> > 1 year ago		
Mitral Valve Regurgitation (MR) on echocardiogram	<input type="radio"/> Not applicable <input type="radio"/> None <input type="radio"/> Trace/trivial <input type="radio"/> 1+ or Mild				

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	<input type="radio"/> 2+ or Moderate <input type="radio"/> 3+ or Moderate to Severe <input type="radio"/> 4+ or Severe		
Documented LVSD?	<input type="radio"/> Yes		<input type="radio"/> No
LVF Assessment?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not done, Reason Documented
Oral Medications during hospitalization <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> ARNI <input type="checkbox"/> ARB	<input type="checkbox"/> Hydralazine Nitrate <input checked="" type="checkbox"/> Mineralocorticoid Receptor Antagonist (MRA)	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> SGLT2 Inhibitor
IV Iron	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not documented
Parenteral Therapies during hospitalization <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> Dopamine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Iron	<input type="checkbox"/> Loop Diuretics <input checked="" type="radio"/> Continuous Infusion <input checked="" type="radio"/> Intermittent bolus <input type="checkbox"/> Milrinone <input type="checkbox"/> Nesiritide Nitroglycerine <input type="checkbox"/> Other IV Vasodilator <input type="checkbox"/> Vasopressin antagonist	
Was the patient ambulating at the end of hospital day 2?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Was DVT prophylaxis initiated by the end of hospital day 2?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	<input type="radio"/> Contraindicated
DVT prophylaxis type	<input type="checkbox"/> Low dose unfractionated heparin (LDUH) <input type="checkbox"/> Low molecular weight heparin (LMWH) <input type="checkbox"/> Warfarin <input type="checkbox"/> Other	<input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Direct thrombin inhibitor <input type="checkbox"/> Venous foot pumps (VFP) <input type="checkbox"/> Intermittent pneumatic compression devices (IPC)	
Was DVT or PE (pulmonary embolus) documented?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
Influenza Vaccination	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/Sensitivity to influenza or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not Documented/UTD		
COVID-19 Vaccination	<input type="radio"/> COVID-19 vaccine was given during this hospitalization <input type="radio"/> COVID-19 vaccine was received prior to admission, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of COVID-19 vaccine <input type="radio"/> Allergy/Sensitivity to COVID-19 or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not Documented/UTD		
COVID-19 Date	_____/_____/_____ <input type="checkbox"/> Unknown		
Is there documentation that this patient was included in a COVID-19 vaccine trial?	<input type="radio"/> Yes <input type="radio"/> No/ND		
Pneumococcal Vaccination	<input type="radio"/> Pneumococcal vaccine was given during this hospitalization <input type="radio"/> Pneumococcal vaccine was received in the past, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of pneumococcal vaccine <input type="radio"/> Allergy/sensitivity or if medically contraindicated to pneumococcal vaccine <input type="radio"/> None of the above/Not Documented/UTD		
DISCHARGE INFORMATION			
What was the patient's discharge disposition on the day of discharge?	<input type="radio"/> 1 – Home <input type="radio"/> 2 – Hospice – Home <input type="radio"/> 3 – Hospice – Health Care Facility <input type="radio"/> 4 – Acute Care Facility <input type="radio"/> 5 – Other Health Care Facility	Discharge Tab	
If other Health Care Facility:	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Inpatient Rehabilitation Facility (IRF)	<input type="radio"/> 6 – Expired <input type="radio"/> 7 – Left Against Medical Advice/AMA <input type="radio"/> 8 – Not documented or Unable to Determine (UTD)	
		<input type="radio"/> Intermediate Care Facility (ICF) <input type="radio"/> Other	

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	<input type="radio"/> Long Term Care Hospital (LTCH)						
Skilled Nursing Facility	<input type="checkbox"/> ND						
If Home, special discharge circumstances:	<input type="radio"/> Home Health Care <input type="radio"/> Homeless		<input type="radio"/> International <input type="radio"/> Prison/Incarcerated		<input type="radio"/> None/UTD		
Primary Cause of Death	<input type="radio"/> Cardiovascular		<input type="radio"/> Non-Cardiovascular		<input type="radio"/> Unknown		
<i>If Cardiovascular:</i>	<input type="radio"/> Acute Coronary Syndrome		<input type="radio"/> Worsening Heart Failure		<input type="radio"/> Sudden Death <input type="radio"/> Other		
When is the earliest physician/APN/PA documentation of comfort measures only?	<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after		<input type="radio"/> Timing unclear <input type="radio"/> Not Documented				
Symptoms (closest to discharge)	<input type="radio"/> Worse <input type="radio"/> Unchanged		<input type="radio"/> Better, Symptomatic <input type="radio"/> Better, Asymptomatic		<input type="radio"/> Unable to determine		
Vital Signs (closest to Discharge)	Weight	_____ <input type="radio"/> Lbs. <input type="radio"/> Kgs.	<input type="radio"/> Not Documented				
	Heart Rate (bpm)	_____	<input type="radio"/> Not Documented				
	Systolic	_____	<input type="radio"/> Not Documented				
	Diastolic	_____					
Exam (Closest to Discharge)	JVP:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, _____ cm				
	Rales:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, <input type="radio"/> <1/3 <input type="radio"/> ≥1/3 <input type="radio"/> N/A				
	Lower Extremity Edema	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, <input type="radio"/> Trace <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+ <input type="radio"/> N/A				
Labs (Closest to Discharge)	Sodium (Na+)	_____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Unavailable				
	BNP	_____ <input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L	<input type="checkbox"/> Unavailable				
	Serum Creatinine	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Unavailable				
	BUN	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Unavailable				
	eGFR (mL/min) NT-proBNP (pg/mL)	<input type="checkbox"/> Not Documented					
	Potassium (K+)	_____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Unavailable				
	Urinary Albumin (mg/dL)						
	Urinary Creatinine (mg/dL)						
	Urinary Albumin-to-Creatinine Ratio (UACR) (mg/g)						
	Ferritin (mg/mL)	_____ <input type="checkbox"/> Unavailable					

DISCHARGE MEDICATIONS *Discharge Tab*

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ACE Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
ACE Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ACEI:	<input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reason		
ARB Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
ARB Medication/ Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ARB:	<input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reasons		
ARNI Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
ARNI Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	<input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input type="checkbox"/> ACE inhibitor use within the prior 36 hours <input type="checkbox"/> Allergy <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hypotension <input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reasons		
Reasons for not switching to ARNI at discharge:	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> ARNI was prescribed at discharge	
If Yes,	<input type="radio"/> NYHA Class I <input type="radio"/> NYHA Class IV		
Beta Blocker Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
Beta Blocker Class	<input checked="" type="radio"/> Evidence-Based Beta Blocker <input checked="" type="radio"/> Non-Evidence-Based Beta Blocker <input type="radio"/> Unknown Class		

<p>Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:</p>	<input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Fluid Overload <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Patient recently treated with an intravenous positive inotropic agent <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		
<p>Beta Blocker Medication/Dosage/Frequency</p>	<p>Medication:</p>	<p>Dosage:</p>	<p>Frequency:</p>
<p>SGLT2 Inhibitor Prescribed?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC</p>		
<p>Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:</p>	<p>Medication: Dosage: Frequency:</p> <input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input type="checkbox"/> Patient currently on dialysis <input type="checkbox"/> Ketoacidosis <input type="checkbox"/> Known hypersensitivity to the medication <input type="checkbox"/> Type I diabetes (not approved for use in patients with Type I diabetes due to increased risk of ketoacidosis) <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reason		
<p>Mineralocorticoid Receptor Antagonist (MRA) Prescribed?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)</p>		
<p>MRA Medication/Dosage/Frequency</p>	<p>Medication:</p>	<p>Dosage:</p>	<p>Frequency:</p>
<p>Was there a dose increase since prior to admission?</p>	<p><input type="radio"/> Yes <input type="radio"/> No/ND</p>		
<p>Potassium ordered or planned after discharge?</p>	<p><input type="radio"/> Yes <input type="radio"/> No/ND</p>		
<p>Renal function test scheduled</p>	<p><input type="radio"/> Yes <input type="radio"/> No/ND</p>		
<p>Contraindications or Other Documented Reason(s) for Not Providing Mineralocorticoid Receptor Antagonist (MRA) at Discharge</p>	<input type="checkbox"/> Contraindicated <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Allergy due to MRA <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women. <input type="checkbox"/> Other contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reason		
<p>Anticoagulation Therapy Prescribed?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)</p>		
<p>Anticoagulation Therapy Class</p>	<input type="checkbox"/> Warfarin <input type="checkbox"/> Direct Thrombin Inhibitor <input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Other <p>Medication: Dosage: Frequency:</p>		
<p>Anticoagulation Contraindication(s):</p>	<p><input type="checkbox"/> Contraindicated</p>		

	<input type="checkbox"/> Allergy to or complication r/t anticoagulation therapy (hx or current) <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other		
Hydralazine Nitrate Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	<input type="checkbox"/> Contraindicated <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason <input type="checkbox"/> Other Reasons		
Anti-hyperglycemic Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
Antihyperglycemic Class/Medication	Class:	Medication:	
	Class:	Medication:	
	Class:	Medication:	
ASA Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
ASA Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Other Antiplatelets Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC (None-Contraindicated)		
Other Antiplatelets Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Clopidogrel Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
Clopidogrel Dosage/Frequency	Dosage:	Frequency:	
Ivabradine Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:	<input type="checkbox"/> Contraindicated <input type="checkbox"/> Allergy to Ivabradine <input type="checkbox"/> Patient 100% atrial or ventricular paced <input type="checkbox"/> Other Contraindications <input type="checkbox"/> Not Eligible <input type="checkbox"/> NYHA class I or IV <input type="checkbox"/> Not in sinus rhythm <input type="checkbox"/> New Onset of HF <input type="checkbox"/> Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated <input type="checkbox"/> Not Tolerant <input checked="" type="checkbox"/> Patient Enrolled in Clinical Trial <input type="checkbox"/> Patient Reasons <input type="checkbox"/> System Reasons <input type="checkbox"/> Other Medical Reasons		

Lipid Lowering Medication Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC					
Lipid Lowering Class/Medication/Dosage/Frequency	Class:	Medication:	Dosage:	Frequency:	
	Class:	Medication:	Dosage:	Frequency:	
	Class:	Medication:	Dosage:	Frequency:	
Omega-3 Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC					
Other Medications					
<input type="checkbox"/> Antiarrhythmic (Discharge) <ul style="list-style-type: none"> <input type="checkbox"/> Amiodarone <input type="checkbox"/> Dofetilide <input type="checkbox"/> Sotalol <input type="checkbox"/> Other antiarrhythmics 		<input type="checkbox"/> Ca Channel Blocker (Discharge) <ul style="list-style-type: none"> <input type="checkbox"/> Digoxin (Discharge) <input type="checkbox"/> Diuretic (Discharge) <ul style="list-style-type: none"> <input type="checkbox"/> Loop Diuretic <input type="checkbox"/> Thiazide Diuretic <input type="checkbox"/> Mavacamten 		<input type="checkbox"/> Nitrate (Discharge) <ul style="list-style-type: none"> <input type="checkbox"/> Ranolazine <input type="checkbox"/> Renin Inhibitor (Discharge) <input type="checkbox"/> Vericiguat <input type="checkbox"/> Other Anti-Hypertensive <input type="checkbox"/> Other medications at discharge 	
OTHER THERAPIES <i>Discharge Tab</i>					
ICD Counseling?	<input type="radio"/> Yes		<input type="radio"/> No		
Reason for not counseling	<input type="radio"/> Yes		<input type="radio"/> No		
Documented Medical Reason(s) for Not Counseling?	<input type="checkbox"/> ICD or CRT-D device in patient <input type="checkbox"/> Multiple or significant comorbidities		<input type="checkbox"/> Limited Life Expectancy <input type="checkbox"/> other reasons not eligible for ICD (e.g. EF>35%, new onset HF) <input type="checkbox"/> Other reasons for not counseling		
ICD Placed or Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No		
Reason(s) for Not Placing or Prescribing?	<input type="radio"/> Yes		<input type="radio"/> No		
Documented Reason(s) for Not Placing or Prescribing ICD Therapy?	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		<input type="checkbox"/> Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset HF		
CRT-D Placed or Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No		
CRT-P Placed or Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No		
Reason for not Placing or Prescribing?	<input type="radio"/> Yes		<input type="radio"/> No		
Documented Reason(s) for Not Placing or Prescribing CRT Therapy?	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Not NYHA functional Class III or ambulatory Class IV <input type="checkbox"/> Patient Reason		<input type="checkbox"/> Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF <input type="checkbox"/> System Reason		
RISK INTERVENTIONS <i>Discharge Tab</i>					
Smoking Cessation Counseling Given	<input type="radio"/> Yes		<input type="radio"/> No		
Smoking Cessation Therapies Prescribed (select all that apply)	<input type="checkbox"/> Treatment Not Specified <input type="checkbox"/> Counseling Only <input type="checkbox"/> Over the Counter Nicotine Replacement Therapy		<input type="checkbox"/> Prescription Medications <input type="checkbox"/> Other		
DISCHARGE INSTRUCTIONS <i>Discharge Tab</i>					
Activity Level	<input type="radio"/> Yes	<input type="radio"/> No	Diet (Salt restricted)	<input type="radio"/> Yes	<input type="radio"/> No
Follow-up	<input type="radio"/> Yes	<input type="radio"/> No	Medications	<input type="radio"/> Yes	<input type="radio"/> No
Symptoms Worsening	<input type="radio"/> Yes	<input type="radio"/> No	Weight Monitoring	<input type="radio"/> Yes	<input type="radio"/> No

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Follow-up Visit Scheduled	<input type="radio"/> Yes	<input type="radio"/> No	Date/Time of first follow-up visit:	___/___/___ :___
Location of first follow-up visit:			<input type="radio"/> Office Visit <input type="radio"/> Home Health Visit	<input type="radio"/> Telehealth <input type="radio"/> Not Documented
Medical or Patient Reason for no follow-up appointment being scheduled?			<input type="radio"/> Yes	<input type="radio"/> No
Follow-up Phone Call Scheduled	<input type="radio"/> Yes	<input type="radio"/> No	Date/Time of first follow-up phone call:	___/___/___
Follow-up appointment scheduled for diabetes management?	<input type="radio"/> Yes	<input type="radio"/> No	Date of diabetes management follow-up visit:	___/___/___
OTHER RISK INTERVENTIONS				Discharge Tab
TLC (Therapeutic Lifestyle Change) Diet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Obesity Weight Management	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Activity Level/Recommendation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referred to Outpatient Cardiac Rehab Program	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Anticoagulation Therapy Education	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Was Diabetes Teaching provided?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
PT/INR Planned Follow-Up	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referral to Sleep Study	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referral to Outpatient HF Management Program	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Outpatient HF Management Program Type(s):	<input type="checkbox"/> Telemanagement		<input type="checkbox"/> Home Visit	<input type="checkbox"/> Clinic-based
Referral to AHA My HF Guide/Heart Failure Interactive Workbook	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Provision of at least 60 minutes of Heart Failure Education by a qualified educator	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Advance Directive Executed	<input type="radio"/> Yes		<input type="radio"/> No	
POST DISCHARGE TRANSITION				Discharge Tab
Care Transition Record Transmitted	<input type="radio"/> By the seventh post-discharge day <input type="radio"/> Exists, but not transmitted by the seventh post-discharge day <input type="radio"/> No Care Transition Record/UTD			
Care Transition Record Transmitted Includes	<input type="checkbox"/> All were included (<i>Check all yes</i>)			
	Discharge Medications	<input type="radio"/> Yes	<input type="radio"/> No	
	Follow-up Treatment(s) and Service(s) Needed	<input type="radio"/> Yes	<input type="radio"/> No	
	Procedures Performed During Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	
	Reason for Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	
	Treatment(s)/Service(s) Provided	<input type="radio"/> Yes	<input type="radio"/> No	
During this admission, was a standardized health related social needs form or assessment completed?	<input type="radio"/> Yes		<input type="radio"/> No/ND	
If yes, identify the areas of unmet social need. (select all that apply):	<input type="checkbox"/> None of the areas of unmet social need listed <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Financial Strain <input type="checkbox"/> Food <input type="checkbox"/> Living Situation/Housing		<input type="checkbox"/> Mental Health <input type="checkbox"/> Personal Safety <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Transportation Barriers <input type="checkbox"/> Utilities	

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