<table>
<thead>
<tr>
<th>FORM SELECTION</th>
<th>LEGEND: (Elements in bold are required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Element used in Achievement</td>
</tr>
<tr>
<td></td>
<td>+Element used in Quality</td>
</tr>
<tr>
<td></td>
<td>^ Element used in Target: HF</td>
</tr>
<tr>
<td></td>
<td># Element used in Target: Type 2 Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HF Limited</th>
<th>Patient ID:</th>
</tr>
</thead>
</table>

### DEMOGRAPHIC DATA

#### Sex
- Male
- Female
- Unknown

#### Patient Gender
- Male
- Female
- Female-to-Male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Genderqueer, neither exclusively male nor female
- Additional gender category or other. __________________________
- Did not disclose.

#### Patient-Identified Sexual Orientation
- Straight or heterosexual
- Lesbian or gay
- Queer, pansexual, and/or questioning
- Something else; please specify. __________________________
- Don’t know
- Declined to answer

#### Date of Birth
- __/__/____ (MM/DD/YYYY)

#### Patient Postal Code
- __________ - __________

#### Payment Source
- Medicare Title 18
- Medicaid Title 19
- Medicare – Private/HMO/PPO/Other
- Medicaid – Private/HMO/PPO/Other
- Private/HMO/PPO/Other
- VA/CHAMPVA/Tricare
- Self-pay/No Insurance
- Other/Not Documented/UTD

#### External Tracking ID
- __________________________

### RACE AND ETHNICITY

#### Race
- American Indian or Alaska Native
- Black or African American
- White
- Asian
- Native Hawaiian or Pacific Islander
- UTD

#### Hispanic Ethnicity
- Yes
- No/UTD

### ARRIVAL AND ADMISSION INFORMATION

#### Internal Tracking ID:
- __________________________

#### Physician/Provider NPI:
- __________________________

#### Arrival Date/Time:
- __/__/____  ___: __________
- Unknown Date/UTD

#### Admission Date:
- __/__/____

#### Point of Origin for Admission or Visit:
- Non-Healthcare Facility Point of Origin
- Clinic
- Transfer From a Hospital (Different Facility)
- Transfer From a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer From Another Health Care Facility
- Emergency Room
- Information Not Available
- Transfer From a Hospice and is Under a Hospice Plan of Care or is Enrolled in a Hospice Program

#### Discharge Date/Time
- __/__/____  ___: __________

### MEDICAL HISTORY

#### Medical History (Select all that apply):
- Anemia
- Heart failure

---

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Page 1 of 9
<table>
<thead>
<tr>
<th>Diseases and Conditions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fib (chronic or recurrent)</td>
<td></td>
</tr>
<tr>
<td>Atrial Flutter (chronic or recurrent)</td>
<td></td>
</tr>
<tr>
<td>ATTR-CM</td>
<td></td>
</tr>
<tr>
<td>CAD</td>
<td></td>
</tr>
<tr>
<td>CardioMEMs (implantable hemodynamic monitor)</td>
<td></td>
</tr>
<tr>
<td>COPD or Asthma</td>
<td></td>
</tr>
<tr>
<td>CRT-D (cardiac resynchronization therapy with ICD)</td>
<td></td>
</tr>
<tr>
<td>CRT-P (cardiac resynchronization therapy-pacing only)</td>
<td></td>
</tr>
<tr>
<td>CVA/TIA</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Dialysis (chronic)</td>
<td></td>
</tr>
<tr>
<td>Emerging Infectious Disease</td>
<td></td>
</tr>
<tr>
<td>MERS</td>
<td></td>
</tr>
<tr>
<td>SARS-COV-1</td>
<td></td>
</tr>
<tr>
<td>SARS-COV-2 (COVID-19)</td>
<td></td>
</tr>
<tr>
<td>Other infectious respiratory pathogen</td>
<td></td>
</tr>
<tr>
<td>Familial hypercholesterolemia</td>
<td></td>
</tr>
</tbody>
</table>

- **No Medical History**
- **History of cigarette smoking? (In the past 12 months)**
  - Yes
  - No
- **History of vaping or e-cigarette use in the past 12 months?**
  - Yes
  - No/ND

### Heart Failure History

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known history of HF prior to this admission?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DIAGNOSIS

#### Admission Tab

<table>
<thead>
<tr>
<th>Heart Failure Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure with CAD</td>
<td></td>
</tr>
<tr>
<td>Heart Failure, no CAD</td>
<td></td>
</tr>
<tr>
<td>Heart Failure, Secondary Diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

#### Atrial Fibrillation (At presentation or during hospitalization)
- Yes
- No

#### Atrial Flutter (At presentation or during hospitalization)
- Yes
- No

#### New Diagnosis of Diabetes
- Yes
- No
- Not Documented

### Active bacterial or viral infection at admission or during hospitalization

- None
- Bacterial infection
- Emerging Infectious Disease
- MERS
- SARS-COV-1
- SARS-COV-2 (COVID-19)
- Influenza
- Seasonal Cold
- Other viral infection

### MEDICATIONS AT ADMISSION

**Admission Tab**

**Medications Used Prior to Admission: [Select all that apply]**

- Patient on no meds prior to admission
- Anti-hyperglycemic medications
- DPP-4 Inhibitors
- GLP-1 receptor agonist
- Insulin
- Metformin
- Sulfonylurea
- Thiazolidinedione
- Other Oral Agents
- Other injectable/subcutaneous agents
- Mavacamten
- Mineralocorticoid Receptor Antagonist (MRA)
- Omecamtiv
- Vericiguat
### EXAMS/LABS AT ADMISSION

<table>
<thead>
<tr>
<th>Exam/Lab</th>
<th>Admission Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>Labs (Closest to Admission)</td>
<td>+Serum Creatinine (Admission)</td>
</tr>
<tr>
<td></td>
<td>mg/dL</td>
</tr>
<tr>
<td></td>
<td>µmol/L</td>
</tr>
<tr>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>+Potassium (K+) (Admission)</td>
<td>mEq/L</td>
</tr>
<tr>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td></td>
<td>mg/dL</td>
</tr>
<tr>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>+ EKG QRS Duration (ms)</td>
<td></td>
</tr>
<tr>
<td>+ EKG QRS Morphology</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>RBBB</td>
</tr>
<tr>
<td></td>
<td>NS-IVCD</td>
</tr>
<tr>
<td></td>
<td>Paced</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
</tr>
</tbody>
</table>

### Clinical Codes

**ICD-10-CM Principal Diagnosis Code**

**IN-HOSPITAL CARE**

#### Procedures

- No Procedures
- Cardiac Cath/Coronary Angiography
- CardioMEMs (implantable hemodynamic monitor)
- Coronary Artery Bypass Graft
- CRT-P (cardiac resynchronization therapy-pacing only)
- Dialysis or Ultrafiltration unspecified
- ICD only
- Mechanical Ventilation
- PCI
- Right Cardiac Catheterization
- TMVR
- Tricuspid Valve Procedure
- Atrial Fibrillation Ablation or Surgery
- Cardiac Valve Surgery
- Cardioversion
- CRT-D (cardiac resynchronization therapy with ICD
- Dialysis
- ECMO
- Intra-aortic Balloon Pump
- Left Ventricular Assist Device
- Pacemaker
- PCI with stent
- Stress Testing
- TAVR
- Transplant (Heart)
- Ultrafiltration

#### *+^ EF – Quantitative

<table>
<thead>
<tr>
<th>%</th>
<th>Obtained:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Admission</td>
</tr>
<tr>
<td></td>
<td>Within the last year</td>
</tr>
<tr>
<td></td>
<td>&gt; 1 year ago</td>
</tr>
</tbody>
</table>

#### *+^ EF – Qualitative

<table>
<thead>
<tr>
<th></th>
<th>Obtained:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Normal or mild dysfunction</td>
<td></td>
</tr>
<tr>
<td>Qualitative moderate/severe dysfunction</td>
<td></td>
</tr>
<tr>
<td>Performed/results not available</td>
<td></td>
</tr>
<tr>
<td>Planned after discharge</td>
<td></td>
</tr>
<tr>
<td>Not performed</td>
<td></td>
</tr>
</tbody>
</table>

#### Documented LVSD?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

#### LVF Assessment?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not done, Reason Documented</th>
</tr>
</thead>
</table>

#### + Was the patient ambulating at the end of hospital day 2?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not Documented</th>
</tr>
</thead>
</table>

#### + Was DVT prophylaxis initiated by the end of hospital day 2?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Contraindicated</th>
</tr>
</thead>
</table>

#### + Influenza Vaccination

- Influenza vaccine was given during this hospitalization during the current flu season
- Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization
- Documentation of patient’s refusal of influenza vaccine
- Allergy/Sensitivity to influenza or if medically contraindicated
- Vaccine not available
- None of the above/Not Documented/UTD

#### COVID-19 Vaccination

- COVID-19 vaccine was given during this hospitalization
- COVID-19 vaccine was received prior to admission, not during this hospitalization
- Documentation of patient’s refusal of COVID-19 vaccine
- Allergy/Sensitivity to COVID-19 or if medically contraindicated
- Vaccine not available
- None of the above/Not Documented/UTD

#### COVID-19 Vaccination Date

__/__/_________
### DISCHARGE INFORMATION

**+[^1] What was the patient’s discharge disposition on the day of discharge?**

1. Home
2. Hospice – Home
3. Hospice – Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not documented or Unable to Determine (UTD)

**If other Health Care Facility:**
- Skilled Nursing Facility (SNF)
- Inpatient Rehabilitation Facility (IRF)
- Long Term Care Hospital (LTCH)
- Intermediate Care Facility (ICF)
- Other

**+[^1] When is the earliest physician/APN/PA documentation of comfort measures only?**

- Day 0 or 1
- Day 2 or after
- Timing unclear
- Not Documented

**Labs (Closest to Discharge)**

<table>
<thead>
<tr>
<th>Test</th>
<th>Value Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum Creatinine (Discharge)</td>
<td>mg/dL</td>
</tr>
<tr>
<td>Potassium (K+) (Discharge)</td>
<td>mmol/L</td>
</tr>
</tbody>
</table>

### DISCHARGE MEDICATIONS

**ACE Prescribed?**
- Yes
- No
- NC (None-Contraindicated)

**ACE Medication/Dosage/Frequency**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Frequency:</th>
</tr>
</thead>
</table>

**Contraindications or Other Documented Reason(s) For Not Providing ACEI:**
- Contraindicated
- Hypotensive patient who was at immediate risk of cardiogenic shock
- Hospitalized patient who experienced marked azotemia
- Other Contraindications
- Not Eligible
- Not Tolerant
- Patient Enrolled in Clinical Trial
- Patient Reason
- System Reason
- Other Reason

**ARB Prescribed?**
- Yes
- No
- NC (None-Contraindicated)

**ARB Medication/Dosage/Frequency**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Frequency:</th>
</tr>
</thead>
</table>

**Contraindications or Other Documented Reason(s) For Not Providing ARB:**
- Contraindicated
- Hypotensive patient who was at immediate risk of cardiogenic shock
- Hospitalized patient who experienced marked azotemia
- Other Contraindications
- Not Eligible
- Not Tolerant
- Patient Enrolled in Clinical Trial
- Patient Reason
- System Reason

---

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<table>
<thead>
<tr>
<th>ARNI Prescribed?</th>
<th>☐ Yes  ☐ No  ☐ NC (None-Contraindicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARNI Medication/Dosage/Frequency</td>
<td>Medication:  Dosage:  Frequency:</td>
</tr>
<tr>
<td>Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:</td>
<td>☐ Contraindicated  ☐ ACE inhibitor use within the prior 36 hours  ☐ Allergy  ☐ Hypertension  ☐ Renal dysfunction defined as creatinine &gt; 2.5 mg/dL in men or &gt; 2.0 mg/dL in women  ☐ Other Contraindications  ☐ Not Eligible  ☐ Not Tolerant  ☐ Patient Enrolled in Clinical Trial  ☐ Patient Reason  ☐ System Reason  ☐ Other Reasons</td>
</tr>
<tr>
<td>Reasons for not switching to ARNI at discharge:</td>
<td>☐ Yes  ☐ No  ☐ ARNI was prescribed at discharge</td>
</tr>
<tr>
<td>If Yes,</td>
<td>☐ New Onset Heart Failure  ☐ Not previously tolerating ACEI/ARB  ☐ NYHA Class I  ☐ NYHA Class IV</td>
</tr>
<tr>
<td>Beta Blocker Prescribed?</td>
<td>☐ Yes  ☐ No  ☐ NC (None-Contraindicated)</td>
</tr>
<tr>
<td>Beta Blocker Class</td>
<td>☐ Evidence-Based Beta Blocker  ☐ Non-Evidence-Based Beta Blocker  ☐ Unknown Class</td>
</tr>
<tr>
<td>Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:</td>
<td>☐ Contraindicated  ☐ Asthma  ☐ Fluid Overload  ☐ Low Blood Pressure  ☐ Patient recently treated with an intravenous positive inotropic agent  ☐ Other Contraindications  ☐ Not Eligible  ☐ Not Tolerant  ☐ Patient Enrolled in Clinical Trial  ☐ Patient Reason  ☐ System Reason</td>
</tr>
<tr>
<td>Beta Blocker Medication/Dosage/Frequency</td>
<td>Medication:  Dosage:  Frequency:</td>
</tr>
<tr>
<td>SGLT2 Inhibitor Prescribed?</td>
<td>☐ Yes  ☐ No  ☐ NC</td>
</tr>
<tr>
<td>Medication:  Dosage:  Frequency:</td>
<td></td>
</tr>
<tr>
<td>Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:</td>
<td>☐ Contraindicated  ☐ Patient currently on dialysis  ☐ Ketoacidosis  ☐ Known hypersensitivity to the medication  ☐ Type I diabetes (not approved for use in patients with Type I diabetes due to increased risk of ketoacidosis)  ☐ Other Contraindications  ☐ Not Eligible  ☐ Not Tolerant  ☐ Patient Enrolled in Clinical Trial  ☐ Patient Reason  ☐ System Reason  ☐ Other Reason</td>
</tr>
<tr>
<td>Mineralocorticoid Receptor Antagonist (MRA) Prescribed?</td>
<td>Yes</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>MRA Medication/Dosage/Frequency</td>
<td>Medication:</td>
</tr>
<tr>
<td>Was there a dose increase since prior to admission?</td>
<td>Yes</td>
</tr>
<tr>
<td>Potassium ordered or planned after discharge?</td>
<td>Yes</td>
</tr>
<tr>
<td>Renal function test scheduled</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Contraindications or Other Documented Reason(s) for Not Providing Mineralocorticoid Receptor Antagonist (MRA) at Discharge**
- Contraindicated
  - Allergy due to MRA
  - Hyperkalemia
  - Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women.
  - Other contraindications
- Not Eligible
- Not Tolerant
- Patient Enrolled in Clinical Trial
- Patient Reason
- System Reason
- Other Reason

<table>
<thead>
<tr>
<th>Anticoagulation Therapy Prescribed?</th>
<th>Yes</th>
<th>No</th>
<th>NC (None-Contraindicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation Therapy Class</td>
<td>Warfarin</td>
<td>Direct Thrombin Inhibitor</td>
<td>Factor Xa Inhibitor</td>
</tr>
<tr>
<td>Medication:</td>
<td>Dosage:</td>
<td>Frequency:</td>
<td></td>
</tr>
</tbody>
</table>

**Anticoagulation Contraindication(s):**
- Contraindicated
  - Allergy to or complication r/t anticoagulation therapy (hx or current)
  - Risk for bleeding or discontinued due to bleeding
  - Serious side effect to medication
  - Terminal illness/Comfort Measures Only
  - Other Contraindications
  - Not Eligible
  - Not Tolerant
  - Patient Enrolled in Clinical Trial
  - Patient Reason
  - System Reason
  - Other

<table>
<thead>
<tr>
<th>Hydralazine Nitrate Prescribed?</th>
<th>Yes</th>
<th>No</th>
<th>NC (None-Contraindicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:</strong></td>
<td>Contraindicated</td>
<td>Not Eligible</td>
<td>Not Tolerant</td>
</tr>
<tr>
<td></td>
<td>Patient Reason</td>
<td>System Reason</td>
<td>Other Reasons</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anti-hyperglycemic Prescribed?</th>
<th>Yes</th>
<th>No</th>
<th>NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihyperglycemic Class/Medication</td>
<td>Class:</td>
<td>Medication:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Class:</td>
<td>Medication:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Class:</td>
<td>Medication:</td>
<td></td>
</tr>
</tbody>
</table>
### ASA Prescribed?
- Yes
- No
- NC (None-Contraindicated)

ASA Medication/Dosage/Frequency
- Medication:
- Dosage:
- Frequency:

### Other Antiplatelets Prescribed?
- Yes
- No
- NC (None-Contraindicated)

Other Antiplatelets Medication/Dosage/Frequency
- Medication:
- Dosage:
- Frequency:

### Clopidogrel Prescribed?
- Yes
- No
- NC

### Clopidogrel Dosage/Frequency
- Dosage:
- Frequency:

### Ivabradine Prescribed?
- Yes
- No
- NC

**Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:**
- Contraindicated
- Allergy to Ivabradine
- Patient 100% atrial or ventricular paced
- Other Contraindications
- Not Eligible
- NYHA class I or IV
- Not in sinus rhythm
- New Onset of HF
- Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated
- Not Tolerant
- Patient Enrolled in Clinical Trial
- Patient Reasons
- System Reasons
- Other Medical Reasons

### Lipid Lowering Medication Prescribed?
- Yes
- No
- NC

Lipid Lowering Class/Medication/Dosage/Frequency
- Class:
- Medication:
- Dosage:
- Frequency:

### Omega-3 Prescribed?
- Yes
- No
- NC

### Antiarrhythmic (Discharge)
- Amiodarone
- Dofetilide
- Sotalol
- Other antiarrhythmics

### Other Medications
- Ca Channel Blocker (Discharge)
- Digoxin (Discharge)
- Diuretic (Discharge)
- Loop Diuretic
- Thiazide
- Diuretic
- Finerenone
- Mavacamten
- Nitrate (Discharge)
- Omecamtiv
- Ranolazine
- Renin Inhibitor (Discharge)
- Vericiguat
- Other Anti-Hypertensive
- Other medications at discharge

### OTHER THERAPIES

**Discharge Tab**

**CRT Therapy**
| +CRT-D Placed or Prescribed? | ☐ Yes | ☐ No |
| +CRT-P Placed or Prescribed? | ☐ Yes | ☐ No |
| +Reason for not Placing or Prescribing? | ☐ Yes | ☐ No |
| +Documented Reason(s) for Not Placing or Prescribing CRT Therapy? | ☐ Contraindications  
☐ Not receiving optimal medical therapy  
☐ Not NYHA functional Class III or ambulatory Class IV  
☐ Patient Reason  
☐ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF  
☐ System Reason |

### Risk Interventions

#### Discharge Tab

**Smoking Cessation Counseling Given**
- ☐ Treatment Not Specified  
- ☐ Counseling Only  
- ☐ Over the Counter Nicotine Replacement Therapy  
- ☐ Prescription Medications  
- ☐ Other

**Smoking Cessation Therapies Prescribed (select all that apply)**
- ☐ Treatment Not Specified  
- ☐ Counseling Only  
- ☐ Over the Counter Nicotine Replacement Therapy  
- ☐ Prescription Medications  
- ☐ Other

### Discharge Instructions

#### Discharge Tab

**Activity Level**
- ☐ Yes  
- ☐ No  
- ☐ Diet (Salt restricted)  
- ☐ Yes  
- ☐ No

**Follow-up**
- ☐ Yes  
- ☐ No  
- ☐ Medications  
- ☐ Yes  
- ☐ No

**Symptoms Worsening**
- ☐ Yes  
- ☐ No  
- ☐ Weight Monitoring  
- ☐ Yes  
- ☐ No

**Follow-up Visit Scheduled**
- ☐ Yes  
- ☐ No  
- ☐ Date/Time of first follow-up visit: ___/___/______ ___:____

**Location of first follow-up visit:**
- ☐ Office Visit  
- ☐ Home Health Visit  
- ☐ Telehealth  
- ☐ Not Documented

**Follow-up Phone Call Scheduled**
- ☐ Yes  
- ☐ No  
- ☐ Date/Time of first follow-up phone call: ___/___/______ ___:____

**Follow-up appointment scheduled for diabetes management?**
- ☐ Yes  
- ☐ No  
- ☐ Date of diabetes management follow-up visit: ___/___/______ (MM/DD/YYYY)  
- ☐ Unknown

### Other Risk Interventions

#### Discharge Tab

**TLC (Therapeutic Lifestyle Change) Diet**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Referred to Outpatient Cardiac Rehab Program**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Referral to Outpatient HF Management Program**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Referral My HF Guide/AHA Heart Failure Interactive Workbook**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Provision of at least 60 minutes of Heart Failure Education by a qualified educator**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?**
- ☐ Yes  
- ☐ No  
- ☐ Not Documented  
- ☐ Not Applicable

**Advance Directive Executed**
- ☐ Yes  
- ☐ No

### Post Discharge Transition

#### Discharge Tab

**Care Transition Record Transmitted**
- ☐ By the seventh post-discharge day  
- ☐ Exists, but not transmitted by the seventh post-discharge day  
- ☐ No Care Transition Record/UTD

**Care Transition Record Includes**
- ☐ All were included (Check all yes)

- ☐ Discharge Medications  
- ☐ Yes  
- ☐ No

- ☐ Follow-up Treatment(s) and Service(s) Needed  
- ☐ Yes  
- ☐ No

- ☐ Procedures Performed During Hospitalization  
- ☐ Yes  
- ☐ No

- ☐ Reason for Hospitalization  
- ☐ Yes  
- ☐ No
<table>
<thead>
<tr>
<th>Treatment(s)/Service(s) Provided</th>
<th>☑ Yes</th>
<th>☑ No</th>
</tr>
</thead>
</table>

### Health Related Social Needs Assessment

**During this admission, was a standardized health related social needs form or assessment completed?**

- ☑ Yes
- ☑ No/ND

**If yes, identify the areas of unmet social need. (select all that apply):**

- None
- Education
- Employment
- Financial Strain
- Food
- Living Situation/Housing

- Mental Health
- Personal Safety
- Substance Abuse
- Transportation Barriers
- Utilities