**FORM SELECTION**

| HF Limited | Patient ID: |

**DEMOGRAPHIC DATA**

**Sex**
- [ ] Male
- [ ] Female
- [ ] Unknown

**Patient Gender Identify**
- [ ] 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:**  ___/___/______  ___: __________

**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
- Atrial Fib (chronic or recurrent)
- Atrial Flutter (chronic or recurrent)
- ATTR-CM
  - Hereditary
  - Wild-type
- CAD
- CardioMEMs (implantable hemodynamic monitor)
- COPD or Asthma
- CRT-D (cardiac resynchronization therapy with ICD)
- CRT-P (cardiac resynchronization therapy-pacing only)
- CVA/TIA
- Depression
- Diabetes
- Dialysis (chronic)
- Emerging Infectious Disease
  - MERS
  - SARS-COV-1
  - SARS-COV-2 (COVID-19)
  - Other infectious respiratory pathogen
- Familial hypercholesterolemia
- Heart Transplant
- Hyperlipidemia
- Hypertension
- ICD only
- Pacemaker
- Peripheral Vascular Disease
- Prior CABG
- Prior MI
- Prior PCI
- Renal insufficiency - chronic (SCr>2.0)
- Sleep-Disordered Breathing
- TAVR
- TMVR
- Tricuspid Valve procedure
- Valvular Heart Disease
- Ventricular assist device
- 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

| Known history of HF prior to this admission? |
|-----------------|----------------|
| Yes | No |

### DIAGNOSIS

#### Heart Failure Diagnosis

- Heart Failure with CAD
- Heart Failure, no CAD
- Heart Failure, Secondary Diagnosis

#### 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

#### 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)
- SGLT2
- Vericiguat
<table>
<thead>
<tr>
<th>EXAMS/LABS AT ADMISSION</th>
<th>Admission Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
</tr>
</tbody>
</table>

### Labs (Closest to Admission)

| + Serum Creatinine (Admission) | __________ | ☐ mg/dL | ☐ µmol/L | ☐ Not Available |
| + Potassium (K+) (Admission)   | __________ | ☐ mEq/L | ☐ mmol/L | ☐ mg/dL        | ☐ Not Available |
| + EKG QRS Duration (ms)        | __________________ | ☐ Not Available |
| + EKG QRS Morphology           | ☐ Normal | ☐ RBBB | ☐ NS-IVCD | ☐ Paced | ☐ Not available |

### 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>
<th>☐ This Admission</th>
<th>☐ Within the last year</th>
<th>☐ &gt; 1 year ago</th>
</tr>
</thead>
</table>

#### EF – Qualitative

<table>
<thead>
<tr>
<th>☐ Not Applicable</th>
<th>☐ Normal or mild dysfunction</th>
<th>☐ Qualitative moderate/severe dysfunction</th>
<th>☐ Performed/results not available</th>
<th>☐ Planned after discharge</th>
<th>☐ Not performed</th>
<th>Obtained:</th>
<th>☐ This Admission</th>
<th>☐ Within the last year</th>
<th>☐ &gt; 1 year ago</th>
</tr>
</thead>
</table>

#### Documented LVSD?

| ☐ Yes | ☐ No |

#### LVF Assessment?

| ☐ Yes | ☐ No | ☐ Not done, Reason Documented |

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

| ☐ Yes | ☐ No | ☐ Not Documented |

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

| ☐ Yes | ☐ No | ☐ Contraindicated |

#### 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

______/______/__________
<table>
<thead>
<tr>
<th><strong>Is there documentation that this patient was included in a COVID-19 vaccine trial?</strong></th>
<th>o Yes  o No/ND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumococcal Vaccination</strong></td>
<td>o Pneumococcal vaccine was given during this hospitalization  o Pneumococcal vaccine was received in the past, not during this hospitalization  o Documentation of patient's refusal of pneumococcal vaccine  o Allergy/sensitivity or if medically contraindicated to pneumococcal vaccine  o None of the above/Not Documented/UTD</td>
</tr>
<tr>
<td><strong>DISCHARGE INFORMATION</strong></td>
<td><strong>Discharge Tab</strong></td>
</tr>
<tr>
<td><em>+</em> What was the patient’s discharge disposition on the day of discharge?</td>
<td>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)</td>
</tr>
<tr>
<td>If other Health Care Facility:</td>
<td>o Skilled Nursing Facility (SNF)  o Inpatient Rehabilitation Facility (IRF)  o Long Term Care Hospital (LTCH)  o Intermediate Care Facility (ICF)  o Other</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
</tr>
<tr>
<td><em>+^</em> When is the earliest physician/APN/PA documentation of comfort measures only?</td>
<td>o Day 0 or 1  o Day 2 or after  o Timing unclear  o Not Documented</td>
</tr>
<tr>
<td>Labs (Closest to Discharge)</td>
<td>+ Serum Creatinine (Discharge)</td>
</tr>
<tr>
<td></td>
<td>+ Potassium (K+) (Discharge)</td>
</tr>
<tr>
<td><strong>DISCHARGE MEDICATIONS</strong></td>
<td><strong>Discharge Tab</strong></td>
</tr>
<tr>
<td>ACE Prescribed?</td>
<td>o Yes  o No  o NC (None-Contraindicated)</td>
</tr>
<tr>
<td>ACE Medication/Dosage/Frequency</td>
<td>Medication:</td>
</tr>
<tr>
<td><strong>Contraindications or Other Documented Reason(s) For Not Providing ACEI:</strong></td>
<td>o Contraindicated  o Hypotensive patient who was at immediate risk of cardiogenic shock  o Hospitalized patient who experienced marked azotemia  o Other Contraindications  o Not Eligible  o Not Tolerant  o Patient Enrolled in Clinical Trial  o Patient Reason  o System Reason  o Other Reason</td>
</tr>
<tr>
<td>ARB Prescribed?</td>
<td>o Yes  o No  o NC (None-Contraindicated)</td>
</tr>
<tr>
<td>ARB Medication/ Dosage/Frequency</td>
<td>Medication:</td>
</tr>
<tr>
<td><strong>Contraindications or Other Documented Reason(s) For Not Providing ARB:</strong></td>
<td>o Contraindicated  o Hypotensive patient who was at immediate risk of cardiogenic shock  o Hospitalized patient who experienced marked azotemia  o Other Contraindications  o Not Eligible  o Not Tolerant  o Patient Enrolled in Clinical Trial  o Patient Reason  o System Reason</td>
</tr>
</tbody>
</table>

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### ARNI Prescribed?

- **Yes**
- **No**
- **NC (None-Contraindicated)**

#### ARNI Medication/Dosage/Frequency

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| o Contraindicated
  - ACE inhibitor use within the prior 36 hours
  - Allergy
  - Hypertension
  - 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 Reasons |

### Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:

- Patient recently treated with an intravenous positive inotropic agent

### Reasons for not switching to ARNI at discharge:

- **Yes**
- **No**

If Yes,

- New Onset Heart Failure
- Not previously tolerating ACEI/ARB

### Beta Blocker Prescribed?

- **Yes**
- **No**
- **NC (None-Contraindicated)**

#### Beta Blocker Class

- Evidence-Based Beta Blocker
- Non-Evidence-Based Beta Blocker
- Unknown Class

### Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:

- 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

### Beta Blocker Medication/Dosage/Frequency

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

### SGLT2 Inhibitor Prescribed?

- **Yes**
- **No**
- **NC**

#### Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:

- 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)
<table>
<thead>
<tr>
<th>Mineralocorticoid Receptor Antagonist (MRA) Prescribed?</th>
<th>Yes</th>
<th>No</th>
<th>NC (None-Contraindicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRA Medication/Dosage/Frequency</td>
<td>Medication:</td>
<td>Dosage:</td>
<td>Frequency:</td>
</tr>
<tr>
<td>Was there a dose increase since prior to admission?</td>
<td>Yes</td>
<td>No/ND</td>
<td></td>
</tr>
<tr>
<td>Potassium ordered or planned after discharge?</td>
<td>Yes</td>
<td>No/ND</td>
<td></td>
</tr>
<tr>
<td>Renal function test scheduled</td>
<td>Yes</td>
<td>No/ND</td>
<td></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>
</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>
</table>
| Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate: | Contraindicated
- Not Eligible
- Not Tolerant
- Patient Enrolled in Clinical Trial
- Patient Reason
- System Reason
- Other Reasons |

<table>
<thead>
<tr>
<th>Anti-hyperglycemic Prescribed?</th>
<th>Yes</th>
<th>No</th>
<th>NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-hyperglycemic Class/Medication</td>
<td>Class:</td>
<td>Medication:</td>
<td>Class:</td>
</tr>
<tr>
<td>Other Therapies</td>
<td>Discharge Tab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRT Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER THERAPIES</th>
<th>Discharge Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td>+CRT-D Placed or Prescribed?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER THERAPIES</th>
<th>Discharge Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td>+CRT-D Placed or Prescribed?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER THERAPIES</th>
<th>Discharge Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td>+CRT-D Placed or Prescribed?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### +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

#### Smoking Cessation Counseling Given
- Yes
- No

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

### Discharge Instructions

#### Activity Level
- Yes
- No

#### Follow-up
- Yes
- No

#### Symptoms Worsening
- Yes
- No

#### Follow-up Visit Scheduled
- Yes
- No

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

#### *+^ Medical or Patient Reason for no follow-up appointment being scheduled?
- Yes
- No

#### Follow-up Phone Call Scheduled
- Yes
- No

#### Follow-up appointment scheduled for diabetes management?
- Yes
- No

### Other Risk Interventions

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

#### ^ Referred to Outpatient Cardiac Rehab Program
- Yes
- No
- Not Documented
- Not Applicable

#### ^ Referred 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

#### 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
- All were included (Check all yes)

#### Care Transition Record Includes
- Discharge Medications
- Follow-up Treatment(s) and Service(s) Needed
- Procedures Performed During Hospitalization
- Reason for Hospitalization
- Treatment(s)/Service(s) Provided

---

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## Health Related Social Needs Assessment

<table>
<thead>
<tr>
<th>During this admission, was a standardized health related social needs form or assessment completed?</th>
<th>☑ Yes</th>
<th>☑ No/ND</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ None</td>
<td>☐ Mental Health</td>
<td></td>
</tr>
<tr>
<td>☐ Education</td>
<td>☐ Personal Safety</td>
<td></td>
</tr>
<tr>
<td>☐ Employment</td>
<td>☐ Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>☐ Financial Strain</td>
<td>☐ Transportation Barriers</td>
<td></td>
</tr>
<tr>
<td>☐ Food</td>
<td>☐ Utilities</td>
<td></td>
</tr>
<tr>
<td>☐ Living Situation/Housing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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