PMT FORM SELECTION	**Legend: Elements in bold are required**
HF	**Patient ID:**

DEMOGRAPHICS — *Demographics Tab*

Gender	○ Male	○ Female	○ Unknown
Date of Birth	___/___/_____ (MM/DD/YYYY)	**Patient Postal Code**	_____ - _____
Payment Source	❑ Medicaid (Title 19) ❑ Medicare (Title 18) ❑ Private/HMO/Other	❑ Medicare – Private/HMO/Other ❑ No Insurance/Not Documented	
External Tracking ID	_____		

RACE AND ETHNICITY — *Demographics Tab*

Race	❑ American Indian or Alaska Native ❑ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	❑ Black or African American ❑ Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ❑ White ❑ UTD
Hispanic Ethnicity	○ Yes	○ No/UTD
If yes,	❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican	❑ Cuban ❑ Another Hispanic, Latino, or Spanish Origin

ARRIVAL AND ADMISSION INFORMATION — *Admission Tab*

Internal Tracking ID	_____	**Physician/Provider NPI**	_____
Arrival Date/Time	___/___/_____ ___: ____	**Admit Date**	___/___/_____
Transferred in (from another ED?)	○ Yes	○ No	
Point of Origin for Admission or Visit	○ 1. Non-Healthcare Facility Point of Origin ○ 2. Clinic ○ 4. Transfer from a Hospital (Different Facility) ○ 5. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	○ 6. Transfer from another Health Care Facility ○ 7. Emergency Room ○ 9. Information not available ○ F. Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program	
Discharge Date/Time	___/___/_____ ___: ____		

MEDICAL HISTORY — *Admission Tab*

Medical History (Select all that apply):

❑ None	❑ Anemia	❑ Atrial Fib (Chronic or Recurrent)
❑ Atrial Flutter (Chronic or Recurrent)	❑ 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	○ Type I
❑ Hyperlipidemia	❑ SARS-COV-1	○ Type II
❑ ICD only	❑ SARS-COV-2	○ ND
❑ Peripheral Vascular Disease	❑ MERS	*Duration:*
❑ Prior MI	❑ Other infectious respiratory pathogen	○ <5 years
❑ Renal Insufficiency – Chronic (SCr>2.0)	❑ Familial hypercholesterolemia	○ 5 - <10 years
❑ Sleep Disordered Breathing (Type):	❑ Heart Failure	○ 10 - <20 years
☐ Obstructive	❑ Hypertension	○ > = 20 years
☐ Central	❑ Pacemaker	○ Unknown
	❑ Prior CABG	

☐ Mixed ☐ Unknown/Not Documented *Equipment Used at Home:* ☐ O2 ☐ CPAP ☐ Adaptive Servo-Ventilation ☐ None ☐ Unknown/Not Documented	❑ Prior PCI ❑ Valvular Heart Disease ❑ Ventricular Assist Device	
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

Etiology: Check if history of:	❑ Ischemic/CAD		❑ Non-Ischemic ☐ Hypertensive ☐ Alcohol/Other Drug ☐ Chemotherapy ☐ Viral ☐ Postpartum ☐ Familial ☐ Other Etiology ☐ Unknown/Idiopathic
Known history of HF prior to this admission?	○ Yes		○ No
# of hospital admissions in past 6 mo. for HF:	○ 0 ○ 1	○ 2 ○ >2	○ Unknown
	❑ Patient Listed for Transplant		

DIAGNOSIS ***Admission Tab***

Heart Failure Diagnosis	❑ Heart Failure, primary diagnosis, with CAD ❑ Heart Failure, primary diagnosis, no CAD ❑ Heart Failure, secondary diagnosis		
Atrial Fibrillation (At presentation or during hospitalization)	○ Yes	○ No	❑ Documented New Onset?
Atrial Flutter (At presentation or during hospitalization)	○ Yes	○ No	❑ Documented New Onset?
New Diagnosis of Diabetes	○ Yes	○ No	○ Not Documented
Basis for Diagnosis	☐ HbA1c ☐ Oral Glucose Tolerance		☐ Fasting Blood Sugar ☐ Test Other
Characterization of HF at admission or when first recognized	○ Acute Pulmonary Edema ○ Dizziness/Syncope ○ Dyspnea ○ ICD Shock/Sustained Ventricular Arrhythmia		○ Pulmonary Congestion ○ Volume overload/Weight Gain ○ Worsening fatigue ○ Other
Other Conditions Contributing to HF Exacerbation *Select all that apply*	☐ Arrhythmia ☐ Pneumonia/respiratory process ☐ Noncompliance - medication		☐ Worsening Renal Failure ☐ Ischemia/ACS ☐ Uncontrolled HTN ☐ Noncompliance – Dietary ☐ Other
Active bacterial or viral infection at admission or during hospitalization	☐ Seasonal cold or flu ☐ Emerging Infectious Disease ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ MERS ☐ Other infectious respiratory pathogen	☐ Bacterial infection	☐ None

MEDICATIONS AT ADMISSION *Admission Tab*

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

- ❑ Patient on no meds prior to admission
- ❑ ACE Inhibitor
- ❑ Aldosterone Antagonist
- ❑ Angiotensin receptor blocker (ARB)
- ❑ Angiotensin Receptor Neprilysin Inhibitor (ARNI)
- ❑ Antiarrhythmic
- ❑ Aspirin
- ❑ Antiplatelet agent (excluding aspirin)
- ❑ Anticoagulation Therapy
  - ○ Warfarin
  - ○ Direct Thrombin Inhibitor
  - ○ Factor Xa Inhibitor
  - ○ Other
- ❑ Anti-hyperglycemic medications:
  - ☐ DPP-4 Inhibitors
  - ☐ GLP-1 receptor agonist
  - ☐ Insulin
  - ☐ Metformin
  - ☐ SLGT2 Inhibitor
  - ☐ Sulfonylurea
  - ☐ Thiazolidinedione
  - ☐ Other Oral Agents
  - ☐ Other injectable/subcutaneous agents
- ❑ Beta-Blocker
- ❑ Ca channel blocker
- ❑ Digoxin
- ❑ Diuretic
  - ☐ Thiazide/Thiazide-like
  - ☐ Loop
- ❑ Hydralazine
- ❑ Ivabradine
- ❑ Lipid lowering agent (Any)
  - ☐ Statin
  - ☐ Other Lipid lowering agent
- ❑ Nitrate
- ❑ Omega-3 fatty acid supplement
- ❑ Renin Inhibitor
- ❑ Other

EXAMS/LABS AT ADMISSION *Admission Tab*

Symptoms (Closest to Admission) *Select all that apply*	❑ Chest Pain ❑ Orthopnea ❑ Palpitations	❑ Dyspnea at rest ❑ Fatigue ❑ PND	❑ Dyspnea on Exertion ❑ Decreased appetite/early satiety ❑ Dizziness/lightheadedness/syncope			
Vital signs (Closest to Admission)	**Height**	_____ ❍ inches ❍ cm	❑ Not Documented			
	Weight	_____ ❍Lbs. ❍Kgs.	❑ Not Documented			
	Waist Circumference	_____ ❍ inches ❍ cm	❑ Not Documented			
	BMI	_____ (Automatically Calculated)				
	Heart Rate	_____ bpm	❑ Not Documented			
	BP-Supine	_____ / _____ mmHg (systolic/diastolic)	❑ Not Documented			
	Respiratory Rate	_____ breaths per minute				
Exam (Closest to Admission)	JVP:	❍ Yes	❍ No	❍ Unknown	If Yes, _____ cm	
	Rales:	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ <1/3	❍ ≥1/3 ❍ N/A
	Lower Extremity Edema	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ Trace ❍ 1+	❍ 2+ ❍ 3+ ❍ 4+ ❍ N/A
Lipids	TC: _____ mg/dL	HDL: _____ mg/dL	LDL: _____ mg/dL	TG: _____ mg/dL	❑ Lipids Not Available	
Labs (Closest to Admission)	**Na**	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable
	BNP	_____	❍ pg/mL	❍ pmol/L	❍ ng/L	❑ Unavailable
	K	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable
	Hgb	_____	❍ g/dL	❍ g/L	❑ Unavailable	
	Albumin	_____	❍ g/dL	❍ g/L	❑ Unavailable	
	NT-proBNP	_____	❍ pg/mL	❍ ng/L	❑ Unavailable	
	SCr	_____	❍ mg/dL	❍ µmol/L	❑ Unavailable	
	BUN	_____	❍ mg/dL	❍ µmol/L	❑ Unavailable	
	Troponin (Peak)	_____ ❍ng/mL❍ug/L	❍ T ❍ I	❍ Normal ❍ Abnormal	❑ Unavailable	
	Ferritin	_____ ng/mL				
	HbA1C	_____ %	❑ Unavailable			
	Fasting Blood Glucose (mg/dL)	_____	❑ Unavailable			

	EKG QRS Duration (ms)	_____	❑ Unavailable	
	EKG QRS Morphology	❍ Normal ❍ LBBB	❍ RBBB ❍ NS-IVCD	❍ Paced ❍ Unavailable

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: __/__/_____	❑ Date UTD
ICD-10-PCS Other Principal Procedure Codes	1.	Date: __/__/_____	❑ Date UTD
	2.	Date: __/__/_____	❑ Date UTD
	3.	Date: __/__/_____	❑ Date UTD
	4.	Date: __/__/_____	❑ Date UTD
	5.	Date: __/__/_____	❑ Date UTD

IN-HOSPITAL CARE *In-Hospital Tab*

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
- ❑ Transplant (Heart)
- ❑ Atrial Fibrillation Ablation or Surgery
- ❑ Cardiac Valve Surgery
- ❑ Cardioversion
- ❑ CRT-D (cardiac resynchronization therapy with ICD
- ❑ Dialysis
- ❑ Intra-aortic Balloon Pump
- ❑ Left Ventricular Assist Device
- ❑ Pacemaker
- ❑ PCI with stent
- ❑ Stress Testing
- ❑ Ultrafiltration

EF - Quantitative	_____ %	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
EF - Qualitative	❍ Not Applicable ❍ Normal or mild dysfunction ❍ Qualitative moderate/severe dysfunction ❍ Performed/results not available ❍ Planned after discharge ❍ Not performed	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
Documented LVSD?	❍ Yes	❍ No	
LVF Assessment?	❍ Yes ❍ No	❍ Not done, Reason Documented	
Oral Medications during hospitalization *Select all that apply*	❑ None ❑ ARNI ❑ ARB	❑ Aldosterone Antagonist ❑ Hydralazine Nitrate	❑ ACE Inhibitor ❑ Beta Blocker
Parenteral Therapies during hospitalization *Select all that apply*	❑ None ❑ Dopamine ❑ Iron ❑ Milrinone ❑ Nesiritide	❑ Nitroglycerine ❑ Vasopressin antagonist ❑ Other IV Vasodilator	❑ Dobutamine ❑ Loop Diuretics ☐ Intermittent Bolus ☐ Continuous Infusion

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

If yes,	❑ Low dose unfractionated heparin (LDUH) ❑ Low molecular weight heparin (LMWH) ❑ Warfarin ❑ Other	❑ Factor Xa Inhibitor ❑ Direct thrombin inhibitor ❑ Venous foot pumps (VFP) ❑ Intermittent pneumatic compression devices (IPC)
Was DVT or PE (pulmonary embolus) documented?	❍ Yes	❍ No/Not Documented
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	
Pneumococcal Vaccination	○ Pneumococcal vaccine was given during this hospitalization ○ Pneumococcal vaccine was received in the past, not during this hospitalization ○ Documentation of patient's refusal of pneumococcal vaccine ○ Allergy/sensitivity to pneumococcal vaccine ○ None of the above/Not Documented/UTD	

DISCHARGE INFORMATION ***Discharge Tab***

Discharge Date/Time	___/___/_____ ___:____	❑ MM/DD/YYYY only
Get With The Guidelines® HF Estimated Mortality Rate	_____ % [Calculated in the PMT]	
For patients discharged on or after 04/01/2011: 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 Advise/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

If Home, special discharge circumstances:	○ Home Health Care ○ Homeless	○ International ○ Prison/Incarcerated	○ None/UTD
Primary Cause of Death	○ Cardiovascular	○ Non-Cardiovascular	○ Unknown
If Cardiovascular:	○ Acute Coronary Syndrome	○ Worsening Heart Failure	○ Sudden Death ○ Other
When is the earliest physician/APN/PA documentation of comfort measures only?		○ Day 0 or 1 ○ Day 2 or after	○ Timing unclear ○ Not Documented
Symptoms (closest to discharge)	○ Worse ○ Unchanged	○ Better, Symptomatic ○ Better, Asymptomatic	○ Unable to determine

Vital Signs (closest to Discharge)	Weight	_____ ❍Lbs. ❍Kgs.				❑ Not Documented	
	Heart Rate	_____ bpm				❑ Not Documented	
	BP-Supine	_____ / ____ mmHg (systolic/diastolic)				❑ Not Documented	
	Respiratory Rate	_____ breaths per minute					
Exam (Closest to Discharge)	JVP:	❍ Yes	❍ No	❍ Unknown	If Yes, _____ cm		
	Rales:	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ <1/3	❍ ≥1/3	❍ N/A
	Lower Extremity Edema	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ Trace ❍ 1+	❍ 2+ ❍ 3+	❍ 4+ ❍ N/A

Labs (Closest to Discharge)	Na	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable
	BNP	_____	❍ pg/mL	❍ pmol/L	❍ ng/L	❑ Unavailable
	SCr	_____		❍ mg/dL	❍ µmol/L	❑ Unavailable
	BUN	_____		❍ mg/dL	❍ µmol/L	❑ Unavailable
	NT-BNP (pg/mL)	_____			❑ Not Documented	
	K	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable

DISCHARGE MEDICATIONS			*Discharge Tab*
Angiotensin Converting Enzyme Inhibitor (ACEI)			
Prescribed?	❍ Yes	❍ No	
If Yes,	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes	❍ No	
Contraindications or Other Documented Reason(s) For Not Providing ACEI:	❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other ❑ Patient Reason ❑ System Reason		
Angiotensin Receptor Blocker (ARB)			
Prescribed?	❍ Yes	❍ No	
If Yes,	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes	❍ No	
Contraindications or Other Documented Reason(s) For Not Providing ARB:	❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other ❑ Patient Reason ❑ System Reason		
Angiotensin Receptor Neprilysin Inhibitor (ARNI)			
Prescribed?	❍ Yes	❍ No	
If Yes,	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes	❍ No	
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	❑ ACE inhibitor use within the prior 36 hours ❑ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women	❑ Allergy ❑ Hyperkalemia ❑ Hypotension ❑ Other medical reasons ❑ Patient Reason ❑ System Reason	
Reasons for not switching to ARNI at discharge:	❍ Yes ❍ No	❍ ARNI was prescribed at discharge	
If Yes,	❑ New Onset Heart Failure ❑ Not previously tolerating ACEI/ARB	❑ NYHA Class I ❑ NYHA Class IV	
Acetylsalicylic acid (ASA)			
Prescribed?	❍ Yes	❍ No	
If Yes,	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes	❍ No	
Anticoagulation Therapy			
Prescribed?	❍ Yes	❍ No	
If Yes,	**Class:** ❑ Warfarin ❑ Direct Thrombin Inhibitor	❑ Factor Xa Inhibitor ❑ Other	
	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes	❍ No	
If Yes, Contraindication(s):	❑ Allergy to or complication r/t anticoagulation therapy (hx or current) ❑ Patient/Family Refused ❑ Risk for bleeding or discontinued due to bleeding ❑ Serious side effect to medication ❑ Terminal illness/Comfort Measures Only		
Clopidogrel			
Prescribed?	❍ Yes	❍ No	
If Yes,	Dosage:	Frequency:	

Contraindicated?	❍ Yes		❍ No	
Other Antiplatelet(s)				
Prescribed?	❍ Yes		❍ No	
If Yes,	Medication:		Dosage:	Frequency:
Beta-Blocker				
Prescribed?	❍ Yes		❍ No	
If Yes,	**Class of Beta Blocker:** ○ Evidence-Based Beta Blocker ○ Non-Evidence-Based Beta Blocker ○ Unknown Class			
	Medication:		Dosage:	Frequency:
Contraindicated?	❍ Yes		❍ No	
Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	❑ Low Blood Pressure ❑ Fluid Overload ❑ Patient Reason ❑ System Reason		❑ Patient recently treated with an intravenous positive inotropic agent ❑ Asthma ❑ Other	
Aldosterone Antagonist				
Prescribed?	❍ Yes		❍ No	
If Yes,	Medication:		Dosage:	Frequency:
Contraindicated?	❍ Yes		❍ No	
Contraindications or Other Documented Reason(s) for Not Providing Aldosterone Antagonist at Discharge	❑ Allergy due to aldosterone receptor antagonist ❑ Hyperkalemia ❑ Other Medical Reasons ❑ Other Contraindications		❑ Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women ❑ Patient Reason ❑ System Reason	
Anti-hyperglycemic Medications:				
Prescribed?	❍ Yes		❍ No	
If Yes,	Class:		Medication:	
	Class:		Medication:	
	Class:		Medication:	
Was there a documented reason for not prescribing a medication with proven CVD benefit?	❍ Yes		❍ No/Not Documented	
Lipid Lowering Medication(s):				
Prescribed?	❍ Yes		❍ No	
If Yes,	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
Contraindicated?	❍ Yes		❍ No	
Omega-3 fatty acid supplement:				
Prescribed?	❍ Yes		❍ No	
Contraindicated?	❍ Yes		❍ No	
Hydralazine Nitrate				
Prescribed?	❍ Yes		❍ No	
Contraindicated?	❍ Yes		❍ No	
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	❑ Medical Reason ❑ Patient Reason ❑ System Reason			

Ivabradine		
Prescribed?	❍ Yes	❍ No
Contraindicated?	❍ Yes	❍ No
Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:	❑ Allergy to Ivabradine ❑ NYHA class I or IV ❑ New Onset of HF ❑ Not in sinus rhythm ❑ Patient 100% atrial or ventricular paced	❑ Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated ❑ Other Medical Reasons ❑ Patient Reasons ❑ System Reasons
Other Medications at Discharge		
❑ Antiarrhythmic ☐ Amiodarone ☐ Dofetilide ☐ Sotalol ☐ Other	❑ Ca Channel Blocker ❑ Digoxin ❑ Diuretic ☐ Loop Diuretic ☐ Thiazide Diuretic	❑ Nitrate ❑ Ranolazine ❑ Renin Inhibitor ❑ Other Anti-Hypertensive ❑ Other

OTHER THERAPIES			***Discharge Tab***
ICD Therapy			
Counseling?	❍ Yes	❍ No	
Reason for not counseling	❍ Yes	❍ No	
Documented Medical Reason(s) for Not Counseling?	❑ ICD or CRT-D device in patient ❑ Multiple or significant comorbidities	❑ Limited Life Expectancy ❑ other reasons not eligible for ICD (e.g. EF>35%, new onset HF) ❑ Other reasons for not counseling	
Placed or Prescribed?	❍ Yes	❍ No	
Reason(s) for Not Placing or Prescribing?	❍ Yes	❍ No	
Documented Reason(s) for Not Placing or Prescribing ICD Therapy?	❑ Contraindications ❑ Not receiving optimal medical therapy ❑ Patient Reason ❑ System Reason	❑ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset HF	
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 ❑ QRS duration <120 ms ❑ System Reason	

RISK INTERVENTIONS		***Discharge Tab***
Smoking Cessation Counseling Given	❍ Yes	❍ No
Smoking Cessation Therapies Prescribed (select all that apply)	❑ Counseling Only ❑ Over the Counter Nicotine Replacement Therapy	❑ Prescription Medications ❑ Other ❑ Treatment Not Specified

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	

Medical or Patient Reason for no follow-up appointment being scheduled?			❍ Yes	❍ No
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:**	___/___/_____

OTHER RISK INTERVENTIONS				***Discharge Tab***
TLC (Therapeutic Lifestyle Change) Diet	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Obesity Weight Management	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Activity Level/Recommendation	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referred to Outpatient Cardiac Rehab Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Anticoagulation Therapy Education	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Was Diabetes Teaching provided?	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
PT/INR Planned Follow-Up	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referral to Sleep Study	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referral to Outpatient HF Management Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
If Yes,	❑Telemanagement		❑ Home Visit	❑ Clinic-based
Referral to AHA My HF Guide/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
	Treatment(s)/Service(s) Provided	❍ Yes	❍ No

ADMIN/JOINT COMMISSION			***Admin/Joint Commission Tab***
CPT Code	_____	Date: __/__/_____	❑ Unknown

What is the patient's source of payment for this episode of care?	❍ Yes	❍ No
Was this Case Sampled?	❍ Yes	❍ No
During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, PR, SCIP)?	❍ Yes	❍ No
Standardized order sets used?	❍ Yes	❍ No
Patient adherence contract/compact used?	❍ Yes	❍ No
Discharge checklist used?	❍ Yes	❍ No

PMT used concurrently or retrospectively or combination?	❍ Concurrently	❍ Retrospectively	❍ Combination

END OF FORM