The Reading Hospital and Medical Center, Sixth Avenue and Spruce Street, West Reading, PA 19611

Heart Failure Readmission Assessment Tool

Patient Name:________________ **Date of Last Discharge:___________**

Account Number:______________ **Date of Current Admit:___ _____ __**

1. Are you following a special diet at home?

   □ No □ Yes; Kind: ____

2. Are you weighing yourself at home EACH day at the same time with similar clothes on?

   □ No □ Yes______ ____

3. Do you know what to do if you gain 3 pounds in 2 days? (write answer)

   ____ □ Don't Know

4. Do you have trouble getting around at home? How so? _________________________

   ____

5. Are you having trouble completing everyday tasks? Which ones?
`

   □ No □ Yes; ____

6. Where do you live? □ At Home □ SNF____________ □ AL____________________

   a. Who helps you at home? □ Spouse □ Adult Child □ Other _____________

   ____

7. What do you think is the reason for your readmission?
   - □ Too much salt?
   - □ Not following your diet.
   - □ Not weighing yourself?
   - □ Not taking medications? Why?
   - □ Not addressing symptoms? (Check below if applicable)
     - □ Shortness of Breath
     - □ Increased Weight
     - □ Unable to lie flat
     - □ Abdominal bloating
     - □ Irregular heart beat

THIS FORM IS NOT A PART OF THE PERMANENT MEDICAL RECORD.
PLACE IN DESIGNATED AREA FOR HF COORDINATOR

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8. What do family members think is cause for readmission?

   ____

9. Did a Home Health nurse come to your house after discharge? □ No □ Yes
   If Yes:

   a. Which agency? (If patient does not know, ask what color folder they have)
      ____

   b. For how long? ________________________________

   c. Were they helpful? _____________________________

10. How many days/weeks from discharge to first doctor appointment? ________________

    a. How do you get to your doctor's appointment? ___ _________________________

11. Did you call your physician/home health before coming to the hospital?

    □ No □ Yes; **Called which physician/ What time of day** ____________________

    a. What were you told to do? ____

    ____

12. General Comments/Outcomes/Recommendations:

Assessment completed by__________________________ ___________ ___________
Date Time

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