EMBOSS WITH PATIENTS HOSPITAL ID CARD

VANCOUVER ISLAND health authority

BC's HEART FAILURE NETWORK
Quality care for quality life.

Name:

PHN:

DOB:

MRN:

Heart Failure Transition Care

Discharge from hospital form. Copy to be faxed to primary care physician/nurse practitioner; copy to patient & chart.

Discharge Diagnosis:	Admission Date day/month/year	Discharge Date day/month/year

PATIENT EDUCATION *(form completed by RN)*

- ☐ Daily weight, before breakfast
- ☐ Limit salt/sodium to less than 2000 mg per day
- ☐ Limit fluid to less than 1500 mL per day or _____ per day, if taking a water pill regularly
- ☐ Take medications as prescribed
- ☐ Daily activity, as tolerated
- ☐ Review Heart Failure Zone sheet daily to monitor symptoms
- ☐ Received copy of *Living Well with Heart Failure*
- ☐ Reviewed use of Heart Failure Zones with patient
- ☐ Reviewed signs & symptoms of worsening heart failure
- ☐ Review heart failure medication use and dose
- ☐ Avoid non-steroidal anti-inflammatory drugs (NSAIDS)
- ☐ Smoking cessation ☐ not applicable

PATIENT SPECIFIC DISCHARGE INFORMATION *(form completed by RN or MD)*

- ☐ BP: Lying _____ Standing _____
- ☐ Pulse: _____
- ☐ Discharge weight: _____ ☐ kg ☐ lbs

NYHA class on discharge: ☐ I ☐ II ☐ III ☐ IV

Ideal dry weight: _____ ☐ kg ☐ lbs

Target INR ☐ 2.0 – 3.0 ☐ 2.5 – 3.5 ☐ not applicable

MOST RECENT TEST RESULTS *(form completed by RN or MD)*

- ☐ Ejection fraction: _____ % Date _____ by ☐ Echo ☐ MUGA ☐ angiogram ☐ _____ day/month/year
- ☐ ECG rhythm _____ Date _____ day/month/year

Na _____ Date of lab results_____ day/month/year

K^+ _____

Cr _____

eGFR _____ INR _____

FOLLOW-UP APPOINTMENTS/REFERRALS ON DISCHARGE *(form completed by clerk)*

Date faxed & initials

- ☐ Primary care practitioner in _____ weeks
- ☐ Specialist _____ in ___ weeks
- ☐ Heart Function Clinic in _____ weeks
- ☐ _____ weeks
- ☐ _____ weeks
- ☐ Home and Community Care
- ☐ Heart Function Clinic (with referral Form)
- ☐ Telehome Care for Home Heart Failure Monitoring
- ☐ BC Palliative Care Benefits Form faxed to: 250-405-3587
- ☐ Palliative Care
- ☐ Other _____

PENDING TESTS TO BE COMPLETE AS OUTPATIENT *(form completed by clerk)*

Blood work ☐ Given requisition, primary care practitioner copied

- ☐ Na, K, Cl, Cr, eGFR in _____ days
- ☐ INR on/in _____ day(s)
- ☐ _____ in _____ days
- ☐ _____ in _____ days

Booked by VIHA: (test, date, time)

- ☐ Holter
- ☐ Nuclear medicine
- ☐ Echo
- ☐ Pacemaker Clinic
- ☐

TESTS TO BE ARRANGED BY GP/NP:

FORM FAXED WITH COPY OF DISCHARGE MEDICATION LIST TO *(form completed by clerk)*:

	Fax Number
Primary care practitioner _____	_____
Cardiologist /Internist_____	_____
MRP _____	_____
Other _____	_____

Date: _____ day/month/year

Signature of person faxing form:

- ☐ Copy of Discharge Medication List faxed to physicians with Transition Tool
- ☐ Copy of Heart Failure Transition Tool given to patient or family member