Detroit Medical Center
Wayne State University

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☐ CHM ☐ RIM
☐ DRH ☐ SGH
☐ HTZ ☐ TCH
☐ HUH ☐ TOSH
☐ HVSH

Folding Perforation

# PATIENT DISCHARGE INSTRUCTION RECORD: Heart Failure

Discharge Date _____

**Appointments and Plan for Continued Care:**

Physician/Clinic _____ Date_____ Phone_____
Physician/Clinic _____ Date_____ Phone_____
Physician/Clinic _____ Date_____ Phone_____

**Comments:** _____

**ACTIVITIES:** ☐ Resume usual activitiesLimitations: ☐ No driving until after first follow-up visit with physician. ☐ No lifting ☐ Alternate activity periods with rest periods; break up large activities into smaller tasks. ☐ Stop any activity at the first sign of chest pain, heaviness or tightness or increased shortness of breath. ☐ Avoid sexual activity until after first follow-up visit with physician. ☐ No bending/twisting at waist. ☐ Return to Work/School: _____

**DIET:** ☐ Low Sodium ☐ Low Saturated Fat ☐ Diabetic ADA _____ calories ☐ Other _____
☐ Special Instructions _____

**REFERRALS FOR CONTINUED CARE:**

☐ Home Care Agency/Phone _____ Date of 1st visit _____
☐ Equipment Supplier/Phone _____ Delivery Date _____
DMC REFERRAL SERVICES 1-888 DMC 2500 (1-888-362-2500)
☐ Site: _____Cardiac Rehab Resources _____ ☐ Declined _____
☐ Site: _____Smoking Cessation Program _____ ☐ Declined ☐ NA _____
☐ Site: _____Diabetic Education Program _____ ☐ Declined ☐ NA _____

**PERSONAL RISK FACTORS:**

a. My Total Cholesterol (TC) = _____ (Goal less than 200) Low Density Cholesterol (LDL) = _____ (Goal less than 100)
High Density Cholesterol (HDL) = _____ (Goal greater than 40) Heart Function Ejection Fraction (EF) _____%
b. Tobacco Use: ☐ No ☐ Yes ☐ Smoking counseling provided ☐ Medication prescribed _____
c. Pneumococcal Vaccine: ☐ No Why?_____ ☐ Yes Date_____
d. Influenza Vaccine: ☐ NA (Apr - Sept) ☐ No Why? _____ ☐ Yes Date_____

**Notify Physician Immediately for any of the following symptoms:**

- Fever above 100.4 or _____
- Heaviness in the chest, palpitations.
- Take your pulse and if greater than 100 or less than 50, you become light-headed, weak, or sweaty.
- You become sweaty, nauseated, light-headed or dizzy after taking medicines.
- If you are on blood thinners and you start bleeding in your urine, stool, or from nose or gums.
- Ankles or legs begin to swell or weight gain of more than _____ pounds per week ☐ Renal Failure _____ pounds per day.
- Call 911 if sudden chest pain unrelieved by medication, lasting longer than 15 minutes or shortness of breath.

**IF YOU HAVE ANY FURTHER QUESTIONS, CONTACT YOUR PHYSICIAN OR CLINIC**



Edge Glue

**DISCHARGE MEDICATIONS** **Inform your Primary Health Care Provider if you are taking:**
**• Vitamins • Over the counter medications • Herbal Supplements • Other medications not listed below**

Please note the following: How often Route: PO = By mouth PR = By rectum TF = Tube feeding
Once a day BID = Twice a day TID = Three times a day Subcut = Under the skin, fatty layer
QID = Four times a day PRN = As needed HS = Bedtime SL = Under the tongue IM = Into the muscle

| MEDICATION/DOSE | How to take | Times a day | Reason for medication | Next dose due |
|---|---|---|---|---|
| Aspirin | | | | |
| Beta Blocker | | | | |
| ACE Inhibitor | | | | |
| Statin | | | | |
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**DO NOT TAKE: Circle and state reason for not taking one of the following drugs:** Aspirin _____
Statin _____ Beta Blocker _____ Ace Inhibitor _____

Physician Signature _____ Date _____

***RN TO COMPLETE THIS SECTION***

**EDUCATION NEEDS ASSESSED AND PROVIDED:** (check those that apply):
☐ Myocardial Infarction/Acute Coronary Syndrome Health Maintenance Agreement given

**Health Care Resources** (check those that apply)
☐ Exercise (Cardiac Rehab) ☐ Smoking Cessation ☐ Weight Monitoring ☐ Diet ☐ Cholesterol Guidelines ☐ Medications
☐ Food Drug Interactions ☐ Pain Management Worsening Signs & Symptoms ☐ Myocardial Infarction ☐ Angina
☐ Other: _____

I have received and understand my discharge instructions:

_____ Date _____
Signature of patient or responsible party (Parent or guardian if patient is a minor)

**DISCHARGE STATUS**

Discharged to: ☐ Home ☐ Other: _____

Accompanied by: _____

If patient is minor, identity of parent/guardian is verified ☐ Yes

_____ Date _____
Signature of RN Completing Discharge

**Please bring a copy of this instruction sheet with you to your physician on your follow up visit**

SAME AS 1