## Guidelines Applied in Practice (GAP)

### HEART FAILURE Tool

#### PATIENT DISCHARGE INFORMATION

I know I need to do the following because I have been treated for heart failure.
My Ejection Fraction is ________ %  (Normal is approximately 50%)

### 1. Diet:

I understand that a low salt (also known as sodium) diet of **2000 mg per day** is recommended for patients with heart failure. This will prevent shortness of breath and swelling in my feet and ankles.

I have received education about a low salt / low sodium diet of **2000 mg per day**.

- [ ] Yes  [ ] No

I understand that I need to read the food labels to know the salt / sodium content of foods.

- [ ] Yes  [ ] No

I am aware that I need to measure and keep my fluid intake to **1.5 - 2 liters per day**. (This includes water, juice, milk, soft drinks, tea/coffee, jello, soups, ice cream, popsicle, alcohol, ice cubes etc.)

- [ ] Yes  [ ] No

### 2. Daily Weights:

I understand that I have to weigh myself daily and I have received instructions about recording my daily weights.

- [ ] Yes  [ ] No

My discharge weight is ________ lbs.

My weight tomorrow morning at home is ________ lbs.

### 3. Take Medicines:

I understand that there are certain medications which will help prevent future heart failure episodes and help me live a longer and healthier life. I will be taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitor OR ARB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta Blocker</td>
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<td></td>
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<tr>
<td>Diuretics</td>
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<tr>
<td>Spironolactone</td>
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<td></td>
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<tr>
<td>Digoxin</td>
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<tr>
<td>Potassium Supplement</td>
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</table>

**CI** = Contraindicated

These are the best practice medications. Depending on my medical diagnosis, I may or may not require all of these medications. I will speak to my doctor if I have any questions.

### 4. I came in with Acute Coronary Syndrome this admission

- [ ] Yes  [ ] No

If yes, I will be taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA</td>
<td></td>
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<td></td>
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<tr>
<td>Platelet inhibitor</td>
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<tr>
<td>Lipid Lowering Agent</td>
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**HEA 170 E (09/2014) 1-PATIENT 2-CART**
5. **Quit Smoking.**
I understand that smoking is a major risk factor in the development of heart disease. Smoking also causes other illnesses which may shorten my life.

I smoke and have been counseled to stop.  
- Yes  
- No  
- CI (non-smoker)

I have been given medication to help me stop smoking.  
- Yes  
- No  
- N/A

If I want to quit smoking, I can call the Smoking Cessation Program I can call **613-761-4753**.

6. **Exercise Regularly.**
I have received exercise guidelines.  
- Yes  
- No

I have been referred to a cardiac rehabilitation program.  
- Yes  
- No

If I haven't received information from the cardiac rehabilitation program within 2 weeks I can call **613-761-4572**.

7. **Learn about heart failure.**
I have received education on heart failure (Heart failure Booklet & Resource materials) during my hospitalization.  
- Yes  
- No

I know what to do if I have a recurrence of my symptoms.  
- Yes  
- No

I have received instructions on my discharge medications.  
- Yes  
- No

8. **Follow-Up with my physician.**

- I have a follow-up appointment made with a cardiologist/internist, Dr. ______________________________ at __________ on ______________________.

- I need to call Dr. ______________________________ at _________ for an appointment within _____ weeks.

I should make an appointment with my family physician within 1-2 weeks and ask him/her about follow up blood work.

9. **Patient Specific Instructions:**
I understand that one of my most important medications is a diuretic. I will be going home on:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

I am aware it is essential to notify my family physician if I experience any of the following:
- Increased difficulty breathing
- Weight gain of more than 2 pounds within a day or 5 pounds within a week
- Swelling of my ankles or legs or abdomen.

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<thead>
<tr>
<th>Nurse Initials</th>
<th>Date</th>
<th>Patient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>