



UNIVERSITY OF OTTAWA
HEART INSTITUTE
INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

Get With the Guidelines HEART FAILURE GAP TOOL PATIENT DISCHARGE INFORMATION

Make sure to fill in all of the boxes

You must write down the EF as soon as the ECHO or MUGA is done

I know I need to do the following because I have been treated for heart failure

My Ejection Fraction is _____ %

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

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

Yes

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

Make sure the Pt's know what consists of fluid (Go over the list with them)

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.

Ask the Pt to fill out wt. tomorrow with home scale

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

ACE Inhibitor **OR** ARB

Yes

No

CI

Beta Blocker

Yes

No

CI

Diuretics

Yes

No

CI

Spironolactone

Yes

No

CI

Digoxin

Yes

No

CI

Potassium Supplement

Yes

No

CI

(CI = Contraindicated)

Each med should have something ticked off. If it's No or CI there must be a reason written in (Reasons for CI would be r/t allergies or intolerances due to a medical issue. Reasons for No would be r/t the pt's condition e.g. Pt is too fluid overloaded at this time)

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. **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 at **613 - 761- 4753.**

5. **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.**

6. **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

7. **Follow - Up with my Physician:**

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

I need to call Dr. _____ @ _____ 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.

8. **Patient Specific Instructions:**

I understand that one of my most important medications is a diuretic. I will

Write down all of the diuretics that the Pt is 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 over a week
- Swelling of my ankles or legs or abdomen.

Go over signs and symptoms with the Pt.

Nurse's Initials

Date

Patient Signature

Date