Heart Failure Patient Admission / ACD Data Sheet

Patient ID Sticker Here:

Arrival Date/Time: _____ **Mode:** Walk in EMS Other_____

If EMS mode – field intervention(s): NIPPV Nitrates Diuretics Other: _____

Previous HX HF: YES/NO If Yes, Type/Class _____

If Yes, most recent Hospitalization Date/Location: _____

Patient symptoms: DIB PND CP (if yes describe) _____

Recent weight gain	☐ YES ☐NO
Edema	☐ YES, if yes where: ☐NO
Other Symptoms	☐ YES ☐ NO

Medication Reconciliation Done: ☐ YES ☐ NO

Precipitant(s) *possible contributing factor/reason for decompensation:*

❑ ACS/Ischemia	❑ Exacerbation of COPD
❑ Non-compliance: Sodium / Fluid intake / Diet non-compliance	❑ ECG Dysrhythmia. If yes, identify rhythm:
❑ Renal Impairment	❑ Myocardial Valve dysfunction
❑ Alcohol Consumption	❑ Smoking
❑ Respiratory infection	❑ Uncontrolled HTN
❑ Non-compliance: Follow up Plan/Missed Appointment	❑ OTHER:
❑ Non-compliance: Medication Obtaining/Missed Doses/etc.	

NYHA Class: 1 2 3 4 **ACC/AHA Stage:** A B C D

Primary RN _____

Patient's Primary Care Prov _____Contacted: Y N Date/Time/Init:

Patient's Cardiologist/HF Spec: _____ Contacted: Y N Date/time/Init:

ED Interventions:

ED HF Order Set used? YES NO

❑ First ECG: Date: Time: QRS duration: ms
❑ First Seen by ED Provider: Date: Time: Provider ID:
❑ NIPPV (initiated in the ED): ☐ YES ☐ NO
❑ Diuretics ☐ YES ☐ NO If yes Dose / Route of Admin_____ Date/Time: _____
❑ Nitrates ☐ YES ☐ NO If yes Dose / Route of Admin _____ Date/Time: _____
❑ Cardiology Consult ☐ YES ☐ NO If yes, name of cardiologist: _____

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ED Interventions (continued):

NYHA Symptoms with Activity documented: YES/NO If yes please specify:

□ NYHA Class I	No symptoms with activity
□ NYHA Class II	Mild symptoms with moderate activity
□ NYHA Class III	Moderate symptoms with minimal activity
□ NYHA Class IV	Symptoms at Rest

HOSPITALIZATION:

□ **Admit to OBS** □ **Admit to Inpatient** **HF Inpatient Order Set Used:** □ YES □ NO

Admit Location: _____ Admit Date/Time: _____

Admit Dr: _____ Initial Patient Weight: _____Lb/Kg

□ Cardiology Consult: □ YES □ NO Contacted: □ YES □ NO Date/time/Init:_____

IN-HOSPITAL EVENTS: Worsening Renal Function	□ YES □NO
Trans to higher level of care	□ YES □NO
Code Blue	□ YES □NO
Stroke	□ YES □NO
MI: □ STEMI □ NSTEMI	□ YES □NO

DAILY EVALUATIONS Electrolytes (*SODIUM/POTASSIUM*)	□ YES □NO
Renal Function (*BUN/CREATININE*)	□ YES □NO
Functional Status (sx with activity):	□ YES □NO
Intake/Output	□ YES □NO
Weight	□ YES □NO
Heart Education *(at least 1 topic addressed daily)*	□ YES □NO

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DEVICE THERAPY:

Screening Criteria for CRT (*must meet ALL 3 requirements*):	**Screening Criteria for ICD** (*must meet ALL 3 requirements*):
☐ LVEF of 35% or less	☐ LVEF of 35% or less
☐ QRS duration of 150 ms or greater	☐ NYHA class II or III
☐ NYHA class II, III, or ambulatory IV	☐ nonischemic DCM or ischemic heart disease at least 40 days post-MI

Device	**Screened (***see above criteria***)**	**Eligible**	**Performed**
CRT	☐ YES ☐NO ☐ **CRT present on admission**	☐ YES ☐NO	☐ YES ☐NO
CRT-D	☐ YES ☐NO ☐ **CRT-D present on admission**	☐ YES ☐NO	☐ YES ☐NO
ICD/AICD	☐ YES ☐NO ☐ **ICD/AICD present on admission**	☐ YES ☐NO	☐ YES ☐NO
LVAD	☐ YES ☐NO ☐ **LVAD on admission** ☐ **Trans for LVAD**	☐ YES ☐NO	☐ YES ☐NO

Criteria for Consideration for Advanced Therapies:

Directive if patient screening for device therapy response - **YES**

1. If no Cardiology consult, consider placing Cardiology consult for further evaluation and discussion with patient/family
2. Cardiology Consult in place: Place note on chart indicating possible candidate for CRT/CRT-D or ICD device based on initial screening criteria
3. For LVAD/Transplant consideration – notify Cardiology for further evaluation based on I NEED HELP screening

Remember acronym to assist in decision making for referral to advanced heart failure specialist:

I-NEED-HELP (also see *Table 6*)

I: IV inotropes
N: NYHA IIIB/IV or persistently elevated natriuretic peptides
E: End-organ dysfunction
E: Ejection fraction ≤35%
D: Defibrillator shocks
H: Hospitalizations >1
E: Edema despite escalating diuretics
L: Low blood pressure, high heart rate
P: Prognostic medication – progressive intolerance or down-titration of GDMT

Diagnostics

Natriuretic Peptides: proBNP

proBNP measured? ☐ YES ☐ NO Date/Time of Initial _____/_____/_____ TIME: _____

Echocardiogram: ☐ **YES** ☐ **NO** If yes, EF _____% Where Echo done: ED Inpatient

If Echo done prior to hospital visit, when _____ where_____EF_____%

ADDITIONAL THERAPY:

Palliative Care	☐ YES ☐NO
Plan to Implant LVAD:	☐ YES ☐NO
Plan / Consult for Transplant	☐ YES ☐NO
Referral to Advanced HF Specialist	☐ YES ☐NO

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DISCHARGE:

☐ Home	☐ Correctional Facility	☐ Transferred to another hospital
☐ Home with HHC	☐ Inpatient Rehabilitation	☐Hospice
☐ Assisted Living	☐ Left Against Medical Advice (AMA)	☐ Expired
☐ ECF/SNF	☐ Long Term Acute Care (LTAC)	

Disch Diagnosis:	

NYHA Class: 1 2 3 4 **ACC/AHA Stage:** A B C D

Medications at Discharge:

Medication Reconciliation Done: ☐ YES ☐ NO

Beta Blocker EF less or equal to 40% - (*Carvedilol, Metoprolol Succinate or Bisoprolol ONLY)* EF greater than 40% - *(Metoprolol tartrate, atenolol, propranolol, etc.)*	**☐ YES ☐ NO ☐ Contraindicated**
ACEi *(Lisinopril, captopril, enalapril, Lotensin, Vasotec, etc)*	**☐ YES ☐ NO ☐ Contraindicated**
ARB *(Azilsartan, Candesartan, Losartan, etc.)*	**☐ YES ☐ NO ☐ Contraindicated**
ARNI *(Sacubitril-valsartan = Entresto)*	**☐ YES ☐ NO ☐ Contraindicated**
Aldosterone Agonist *(Spironolactone, Eplerenone, etc)*	**☐ YES ☐ NO ☐ Contraindicated**
Hydralazine *(Apresoline, Hyrda-Zide, Apresazide, Serpazide)*	**☐ YES ☐ NO ☐ Contraindicated**
Home INOTROPE infusion	**☐ YES ☐ NO**

DISCHARGE PACKET REVIEWED WITH AND PROVIDED TO PATIENT / FAMILY /CAREGIVER:

MED LIST GIVEN TO Pt/Fam	☐ YES ☐NO
Heart Failure Patient Checklist	☐ YES ☐NO
Patient Daily Self-Check (Red-Yellow-Green) Checklist	☐ YES ☐NO
Strategies to Improve Medication Management and Daily Weights	☐ YES ☐NO

FOLLOW-UP VISIT(S) Scheduled:

On ____/____/_____at _____ with _____

On ____/____/_____at _____ with _____

Medical Records transmitted to follow-up provider(s): ☐ YES ☐ NO Date/Time _____

Completed by_____ date/time_____