

DATE _____ TIME _____

DIAGNOSIS _____

HEART HEALTH

- Daily Weight Monitoring: Record your weight daily in a notebook. Call MD if weight gain of 2-3 lbs. or more per day over 2 days.
- Your Diet: Avoid salt and eat foods low in sodium, low in fat. Read all labels. Follow the diet prescribed by your MD.
- Medications: Keep a list of your current medications. Use a medication organizer to keep track of your medication. Take medication as instructed. Bring medications to MD office.
- Activity as Tolerated: Exercise as instructed by your MD.

INCISION / WOUND CARE

- Wash your incision / wound with soap and water in the Tub Shower
- Dressing care per MD / RN.
- You have steri-strips on your incision which will fall off by themselves. You can wash over them gently, and if they fall off, leave them off.
- It is normal to have soreness in and around your incision/wound, which may increase as you become more active as compared to when you are resting.
- Keep pressure off wound. Turn and re-position at least every 2 hours.

EDUCATIONAL INFORMATION

Information Provided and Reviewed:

- COPD / Asthma
- Cardiac Risk Factors
- Heart Failure
- Atrial Fibrillation
- Heart Attack
- Pacemaker / ICD
- Smoking Cessation
- Cardiac Rehab
- Post Cath
- Post Op Activities
- Diabetes
- Diet
- Wound Care
- Pressure Ulcer Care
- Stress Management
- Other

CALL YOUR DOCTOR IF ANY OF THESE OCCUR.

- Weight gain greater than 2-3 lbs. or more periodically over 2 days.
- Shortness of breath
- Swelling of your ankles or legs
- Persistent cough
- Chest pain

- If you have more redness or drainage from your incision
- If you have nausea and vomiting that does not goes away in 24 hours
- If any symptoms worsen
- If you develop a fever (temperature over 100°F or 38°C)
- If you have more pain in the area of your incision

The #1 way to improve your overall health is to stop smoking.

HOME HEALTH INFORMATION REFERRAL REQUEST IF APPLICABLE

REFERRAL TO: _____ PHONE # _____ AGENCY NOTIFIED

FAX PATIENT FACE SHEET AND THIS REFERRAL TO:
FAX # _____

CONTACT PERSON # _____ AND VISIT @ _____

SERVICE REQUESTED: Skilled nursing HHA PT OT Speech MSW Other

DIAGNOSIS: _____ SURGERY: _____
SURGERY DATE: _____

SKILLED NURSING NEED i.e. teaching, review meds, monitoring wt compliance issues

TREATMENT PLAN: i.e. Wound care, pressure ulcer prevention

ALLERGIES: _____

ACTIVITIES: _____

VITAL SIGNS: BP _____ Pulse _____ Hgb _____
TEMP _____ HT _____ WT _____ Hct _____

MEDICAL SUPPLIES

- Walker Oxygen device/flow _____
- Wheelchair Other _____
- Hospital bed Heel Lift R L
- Commode

TRANSFER INFORMATION (SNF, INPATIENT REHAB, ASSISTED/ADULT HOME)

TRANSFER TO: (name) _____ (phone) _____

VITAL SIGNS: BP _____ Pulse _____ Hgb _____ BUN _____
TEMP _____ HT _____ WT _____ Hct _____ CR _____

Comments: _____

- MD order for discharge
- Pt/FAMILY notified
- Report given to facility
- Chart copied
- PRI enclosed for SNF
- Transfer time _____
Via _____
- Adult Home Form

NOTE: TRANSFER TO ACUTE CARE MUST USE INTERAGENCY FORM

I have been informed of area home health care agencies and understand that Hudson Valley Home Care is an affiliate of VBMC

M.D.

REVIEW AND INITIAL

R.N.

INITIAL OF PATIENT OR RESPONSIBLE OTHER
