Discharge Instructions - Congestive Heart Failure

- Weigh yourself daily and notify your physician of a weight gain of 3 – 5 pounds in 3 days. Keep a record of your weight. (Patient provided with log)

- Follow a low salt diet – avoid using salt at the table, avoid / limit use of canned soups, processed / packaged foods, salted snacks, olives and pickles. Do not use a salt substitute without consulting your physician.

- Notify your physician if you have an increase in:
  - Chest pain / discomfort
  - Shortness of breath
  - Swelling in your legs, hand, feet or if your heart rate becomes fast or irregular
  - Any dizzy spells or blackouts
  - Weight gain of more than 3 – 5 pounds in 3 days

- Take your medication as prescribed (Patient provided with food/drug/herbal interaction booklet and information sheets on discharge medications)

- CHF education completed and packet provided.

- **IF YOU SMOKE – STOP!** “Kick the Habit” Smoking Cessation Program offered at Memorial Hospital HealthLink. Call 444-CARE (2273) for more information.

Activity: __________________________________________________________

Specific instructions: ________________________________________________

_________________________________________________________________

Discharge medications:

<table>
<thead>
<tr>
<th>These drugs have proven survival benefit in the treatment of CHF</th>
<th>Other medications that you may go home on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE-I / ARB</td>
<td>Diuretic:</td>
</tr>
<tr>
<td>Beta Blocker:</td>
<td>Digoxin:</td>
</tr>
<tr>
<td>Aldosterone Blocker:</td>
<td>Statin:</td>
</tr>
<tr>
<td></td>
<td>Aspirin:</td>
</tr>
</tbody>
</table>

- Use “Additional Information Sheet” for any remaining medications

Appointments / Referrals: (Follow up with/on/phone number)

Cardiologist__________________ ____________________________

Primary Care__________________ ____________________________

Other: __________________________ ____________________________

☐ Smoking Cessation Counseling, referral to cessation program & option for replacement/suppression treatment provided (if applicable)
☐ Pain management education provided
☐ Diabetes education provided (if applicable)
☐ Food/ Drug Herbal Interaction education completed
☐ Patient verbalizes understanding of all discharge instructions.

Patient discharged to__________________ at________________ mode________________ accompanied by__________________

☐ Valuable / Medications / Prescriptions given to: ☐ N/A ☐ Patient ☐ Family ☐ Other:__________________

Signature of patient/family__________________ RN signature__________________ Date________________