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:**

<table>
<thead>
<tr>
<th>Discharge medications:</th>
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<tr>
<td>These drugs have proven survival benefit in the treatment of CHF</td>
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<tr>
<td>ACE-I / ARB</td>
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<tr>
<td>Beta Blocker:</td>
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<tr>
<td>Aldosterone Blocker:</td>
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</table>

- Use “Additional Information Sheet” for any remaining medications

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

<table>
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<tr>
<th>Cardiologist</th>
<th>Primary Care</th>
<th>Other:</th>
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- Smoking Cessation Counseling, referral to cessation program & option for replacement/suppression treatment provided (if applicable)
- Pain management education provided
- Food/ Drug Herbal Interaction education completed
- Diabetes education provided (if applicable)
- 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 __________

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