Do not take other or additional medications at home without checking with your physician. Remember to take this sheet to your next doctor’s appointment.

### MEDICATIONS

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY/indicate times to be taken</th>
<th>NEXT DOSE DUE</th>
<th>SPECIAL INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOR CARDIOVASCULAR PATIENTS</td>
<td></td>
<td>REMEMBER CORE MEASURES *</td>
<td></td>
<td>(i.e. Food/Drug Interactions)</td>
</tr>
<tr>
<td>☐ ASPIRIN *</td>
<td></td>
<td>mg Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ PLAVIX</td>
<td>75 mg</td>
<td>Daily</td>
<td></td>
<td></td>
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<tr>
<td>☐ ACEI *</td>
<td></td>
<td></td>
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<tr>
<td>☐ ARB *</td>
<td></td>
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<tr>
<td>☐ BETA BLOCKER *</td>
<td></td>
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</tr>
<tr>
<td>☐ STATIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER MEDICATIONS</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

SOME MEDICATIONS MAY HAVE FOOD INTERACTIONS. READ WRITTEN MATERIAL PROVIDED AND ASK YOUR DOCTOR & PHARMACIST.

### SPECIAL INSTRUCTIONS

Call for a follow-up appointment @

### COMMUNITY RESOURCES / REFERRALS

WEEKLY SMOKERS SUPPORT GROUP 845-483-6470
SMOKERS HOT LINE: 1-866-697-8487
WWW.CDC.GOV/TOBACCO
☐ WOUND CARE CENTER 845-431-2400
☐ CARDIAC REHAB
(For unstable angina, heart attack, Coronary bypass)
☐ OTHER
☐ IF YOU NEED INFORMATION ON COMMUNITY RESOURCES
CALL VBMCCASE MANAGEMENT: 845-437-3101

### IMMUNIZATIONS

☐ Assessment/Education done
☐ NA
☐ Pneumococcal, Date: __________
☐ Influenza, Date: __________

May we contact you after discharge? ☐ Yes ☐ No
At what number may we reach you?
What is the preferred time to call?

M.D.
R.N.

SIGNATURE OF PATIENT OR RESPONSIBLE OTHER

☐ I have reviewed and assessed that the patient and/or family understand the information on this document
**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 or 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.

**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 go 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

**EDUCATIONAL INFORMATION**
- 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

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

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**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 DATE: ____________________________

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

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

MEDICAL SUPPLIES

□ Walker □ Oxygen device/flow
□ Wheelchair □ Hospital bed □ Heel Lift □ R □ L

□ Commode

VITAL SIGNS: BP _______________ Pulse _______________ Hgb _______________ Hct _______________

TEMP ________ HT ________ WT ________

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

TRANSFER TO: (name) ____________________ (phone) ____________________

VITAL SIGNS: BP _______________ Pulse _______________ Hgb _______________ Hct _______________ BUN _______________ CR _______________

TEMP ________ HT ________ WT ________

Comments: ____________________________

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 VBMCH.

M.D. ____________________________

R.N. ____________________________

INITIAL OF PATIENT OR RESPONSIBLE OTHER ____________________________

MD-361A (rev. 3/05) #1634

CHART