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>
</tr>
<tr>
<td>□ ACEI *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ ARB *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ BETA BLOCKER *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ STATIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER MEDICATIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</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 VBMHC CASE 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 □ Shower
- Dressing care per MD / RN.
- You have steri-strips on your incision which will fall off by themselves. You can wash 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

---

**HOME HEALTH INFORMATION REFERRAL REQUEST IF APPLICABLE**

<table>
<thead>
<tr>
<th>REFERRAL TO:</th>
<th>PHONE #</th>
<th>□ AGENCY NOTIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAX #</td>
<td>CONTACT PERSON #</td>
<td>AND VISIT @</td>
</tr>
<tr>
<td>SERVICE REQUESTED:</td>
<td>□ Skilled nursing □ HHA □ PT □ OT □ Speech □ MSW □ Other</td>
<td></td>
</tr>
<tr>
<td>DIAGNOSIS:</td>
<td></td>
<td>SURGERY:</td>
</tr>
<tr>
<td>SKILLED NURSING NEED i.e. teaching, review meds, monitoring wt compliance issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**ALLERGIES:**

**ACTIVITIES:**

**VITAL SIGNS:**
- BP
- Pulse
- Hgb
- TEMP
- HT
- WT
- Hct
- Commode

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

---

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

<table>
<thead>
<tr>
<th>TRANSFER TO: (name)</th>
<th>(phone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VITAL SIGNS:</td>
<td>BP</td>
</tr>
<tr>
<td>TEMP</td>
<td>HT</td>
</tr>
<tr>
<td>Hct</td>
<td>CR</td>
</tr>
</tbody>
</table>

**Comments:**

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**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

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**CHART**

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