

Discharge Instructions:

Patient Name: _____

Date: _____

Diagnoses:	*Is Patient a Smoker? (smoked in last year) ___ Yes ___ No
	*Smoking Cessation Packet Given? ___ Yes ___ No

- | | |
|----------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> *Heart Failure | Pneumococcal Vaccine: ___ Given ___ Refused |
| <input type="checkbox"/> *Acute Myocardial Infarction (Heart Attack) | ___ Patient has had vaccine (date) _____ |
| <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Post-Op Procedure: _____ | Flu Vaccine: ___ Given ___ Refused |
| <input type="checkbox"/> Diabetes | ___ Patient had this season |
| <input type="checkbox"/> Other (Specify) _____ | Oct. thru February discharges) |

***Medications: Each medication, strength, route, times must be listed**

Name of Medication & Strength	Time (& Next dose due)	Reason for Drug

***Diet:** _____ ***Activity:** _____

- *Weigh yourself every day, write it down, and take with you to follow-up appointment

***Call your doctor if you have:**

- Weight gain of 2-4 lbs over 2-3 days
- Worsening swelling
- Shortness of Breath or have to sleep with more than one pillow
- Temperature greater than _____
- Questions or Concerns: Call _____

***Follow up with Dr.** _____ **in** _____

Home Health _____ **Phone:** _____

I understand the discharge instructions: _____
(signature of Patient or Caregiver)

Staff Signature/Credentials _____

All * Asterisked Items Must be Addressed for Heart Failure and Acute Myocardial Infarction Patients