Heart Failure: Patient Teachback Form For Successful Discharge (Page 1 Of 3)

I was in the hospital because:

_____

_____

If I have the following problems...	**I should...** *(fill in what you should do)*
1. Weight gain of 3 pounds in 1 day or 5 pounds in 1 week.	_____
2. Swelling in my feet, ankles, hands or stomach	_____
3. Lack of energy feeling more tired	_____
4. Feeling my heart race or feeling like I am going to faint	_____
5. Difficulty sleeping flat or performing normal daily tasks	_____
6. Dry hacking cough or feeling chest pain	_____

Important Contact Information:

My Primary Doctor is: _____ Phone Number: _____

My Hospital Contact is: _____ Phone Number: _____

My Heart Doctor (Cardiologist) is: _____ Phone Number: _____

My Pharmacy is: _____ Phone Number: _____

I have the following home service: ☐ N/A ☐ Home Health ☐ Hospice ☐ Private Duty

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Heart Failure: Patient Teachback Form For Successful Discharge (Page 2 Of 3)

My Appointments:

1. _____ on ___/___/_____ at ___:___ am/pm
2. _____ on ___/___/_____ at ___:___ am/pm
3. _____ on ___/___/_____ at ___:___ am/pm

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. _____
2. _____
3. _____
4. _____

My Heart Failure Care Plan:

_____

_____

_____

Lifestyle Changes:

After leaving the hospital, I will make the following changes because of: _____

_____

Personal Goal: _____

Activity: _____,because _____

Diet: _____,because _____

Smoking:

☐ Non-Smoker *Date last smoked:* _____ ☐ Smoker *Plan for quitting:* _____

_____

Heart Failure: Patient Teachback Form For Successful Discharge (Page 3 Of 3)

Medications:

When I leave the hospital and go home, I will be taking the medications on my Prescription Form.
Please initial the following statements that apply to you.

_____ I understand which medicines I took before I came to the hospital, but will now STOP.

_____ I understand which medicines I will continue taking and the new medicines I will now add.

_____ I understand why and when I need to take each medicine.

_____ I understand which side effects to watch for.

_____ I have a bathroom scale or will make plans to get one.

Please bring all of your medicines to your follow up appointments.

I understand my treatment plan. I feel able and willing to actively participate in my own care:

_____

Patient/Caregiver Signature
Relationship to Patient _____

_____

Provider Signature and Title

_____

Date