The following checklist is intended to assist healthcare providers in reducing the risk of readmission for patients with heart failure transitioning to home care. Use this checklist to ensure that your patient/caregiver understands the discharge instructions and has the ability to perform self-care.

American Heart Association | American Stroke Association

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Heart.org/HFGuidelinesToolkit

Medication Management

- ☐ Was a prescription given?
- ☐ Is the patient/caregiver able to get the prescription filled?
- ☐ Is the prescribed medication listed on patient's insurance formulary?
- ☐ Were medications and instructions on how to take them listed for the patient?
- ☐ Are there any known adverse reactions to the medications?
- ☐ Was a list with instructions on how to take the medications provided to a caregiver?
- ☐ Does the patient/caregiver understand the importance of medication adherence?

Self-Management

- ☐ Does the patient have access to transportation?
- ☐ Does the patient have financial barriers?
- ☐ Does the patient have language barriers?
- ☐ Is the patient able to perform care?
- ☐ Does the patient understand and know how to recognize new or worsening signs and symptoms of HF?

Will the patient be able to adhere to:

- ☐ Medication regimen?
- ☐ Low-sodium diet?
- ☐ Daily weigh-in?
- ☐ Exercise/activity plan or recommendation to participate in cardiac rehab?
- ☐ Monitoring new or worsening signs or symptoms of HF?

Lack of Communication (pending diagnostic results not communicated with PCP)

- ☐ Was transition/discharge summary sent to Primary Care Provider?
- ☐ Did a PCP note at the time of transition that a provider had been found prior to discharge?

Referral/Outpatient Needs Process

- ☐ Was a referral noted?
- ☐ Was there a referral follow-up?
  Name: _____
- ☐ Was there a referral to an agency that was unable to meet individual needs?
  Name: _____
- ☐ Was there an unaddressed comorbidity?
- ☐ Was mobility/home safety assessed?