BC's HEART FAILURE NETWORK
Quality care for quality life.

Heart Function Clinic Patient Visit Assessment Form

*** not a key element**

Addressograph

Health Authority Logo
Visit Date_______________

HISTORY					
Since Last Visit	**Yes**	**No**	**# Visits/days**	**Reason**	
€ Dr/visit outside of clinic € ER visits € Hospitalizations					
Device	CRT Yes No	ICD Yes No	Shocks Yes No	How may?	Pacemaker: Yes No Type:

Symptoms	**Better**	**Same**	**Worse**	**Symptoms**	**Yes**	**No**	**Notes**
Fatigue				PND			
Dyspnea				Orthopnea			
Anxiety				Palpitations			
Depression							
Angina				Lightheadedness			
Swelling				GI Complaints			
Legs				Limits to ADL's			
Abdomen				Extra Diuretics			
# of pillows under the head	Normally		Currently	Medication list reviewed with patient			
Social	Notes:			* **CPX:** Date:	EF________% Date: _________ Echo MIBI MUGA (circle)		

PHYSICAL EXAM						
Weight	Last Visit		Current		**Target**	
Vital Signs	B/P	Lying	Standing	HR	O2 Sat	
Heart Sounds (circle)	S1 S2 S3 S4		**Murmurs** Grade	Mitral S/D	Aortic S/D	Other
Lungs: (circle)	Clear Crackles <1/4 >1/2		**JVP (cm)**	**HJR**	**Ascites**	
Edema:	+1 +2 +3 +4 (circle)		**Fluid Volume**	Euvolemic	Dry	Overloaded
Activity	Type:	Time:	*Program:* Structured, Unstructured None			
NYHA Class	I II III IV N/A (circle)		* **CCS Angina class**	0 I II III IV N/A (circle)		
Clinical Status	Better	Same	Worse	Stable:	Yes	No

EDUCATION		PLAN OF CARE	
Topic:	**Yes**	**Nurse**	**MD/NP (Directives and/or plan of care)**
Disease			
Medications			
Fluid			
Salt			
Activity/Exercise			
Smoking			
ETHOL			
Travel			
Stress Management			
Vaccinations			
Advanced care planning			

INVESTIGATIONS				
B/W	Lytes	NT pro BNP	BNP	ECG
Other				

Referrals ____

Follow Up: Weeks ________________ Months ______________ Other: ______________

Signatures _________________________ MD NP RN

Print Name _________________________ MD NP RN