

|                 |                  |                  |
|-----------------|------------------|------------------|
| <b>Pt Name:</b> | <b>Pt. ID #:</b> | <b>Date:</b> / / |
|-----------------|------------------|------------------|

**Pt Knowledge**

1. Does the pt. understand their disease process? **Yes No** 2. Did the pt. understand their discharge orders? **Yes No**

**Weight**

Daily weights? **Yes No** Goals weight in Pounds: \_\_\_\_\_ **Lbs.** Current Weight in Pounds: \_\_\_\_\_ **Lbs.**

**Assessment**

|                            |                                 |                                |                                    |
|----------------------------|---------------------------------|--------------------------------|------------------------------------|
| <b>Shortness of Breath</b> | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Fatigue</b>             | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Dyspnea</b>             | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Orthopnea</b>           | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Cough</b>               | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Pedal Edema</b>         | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |
| <b>Sputum Production</b>   | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> Unchanged |

**Blood pressure**

Normal/Goal Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ mmHg Current Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ mmHg

**Edema**

Pitting Edema Scale  1+ (2mm)  2+ (4mm)  3+ (6mm)  4+ (8mm)

**ECG / 12-lead Interpretation**

|  |                 |
|--|-----------------|
| <b>ECG:</b>  | <b>12-Lead:</b> |
| 12-lead Transmitted <input type="checkbox"/> Yes <input type="checkbox"/> No           |                 |
| Access to preexisting 12-lead <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |

**ADL**

| Function             | Independent | Needs Help | Dependent | Does not do |
|----------------------|-------------|------------|-----------|-------------|
| Bathing              |             |            |           |             |
| Dressing             |             |            |           |             |
| Grooming             |             |            |           |             |
| Oral Care            |             |            |           |             |
| Toileting            |             |            |           |             |
| Transferring         |             |            |           |             |
| Walking              |             |            |           |             |
| Climbing stairs      |             |            |           |             |
| Eating               |             |            |           |             |
| Shopping             |             |            |           |             |
| Cooking              |             |            |           |             |
| Managing medications |             |            |           |             |
| Using the Phone      |             |            |           |             |
| Housework            |             |            |           |             |
| Doing Laundry        |             |            |           |             |
| Driving              |             |            |           |             |
| Managing Finances    |             |            |           |             |

**Lab Results (i-STAT)**

|  |  |  |  |  |  |
|--|--|--|--|--|--|
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Vital Signs**

| Time | BP | HR | RR | SpO2 | Weight | BG | Temp | GCS |
|------|----|----|----|------|--------|----|------|-----|
|      |    |    |    |      |        |    |      |     |
|      |    |    |    |      |        |    |      |     |

**Notes**

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**Referrals**

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|---|--|
| <b>Green zone: All Clear</b>  | <b>Green Zone Means:</b>   |
| <input type="checkbox"/> No Shortness of breath<br><input type="checkbox"/> No swelling<br><input type="checkbox"/> No weight gain<br><input type="checkbox"/> No Chest pain<br><input type="checkbox"/> No decrease in Pt ability to maintain activity level   | <ul style="list-style-type: none"><li>• Symptoms are under control</li><li>• Continues with medication regiment</li><li>• Continue daily weights</li><li>• Follow low salt diet</li><li>• Keep all appointments with physician</li></ul> |
| <b>Yellow Zone: Caution</b>   | <b>Yellow Zone Means:</b>  |
| <input type="checkbox"/> Weight gain of 3 or more pounds<br><input type="checkbox"/> Increased cough<br><input type="checkbox"/> Increased swelling<br><input type="checkbox"/> Increased shortness of breath with activity<br><input type="checkbox"/> Increase in the number of pillows needed<br><input type="checkbox"/> Anything else unusual that bothers you           | <ul style="list-style-type: none"><li>• Symptoms may indicate that the pt needs adjustment in their medications</li></ul>  |
| <b>Red Zone: Medical Alert</b>  | <b>Red Zone Means:</b>   |
| <input type="checkbox"/> Unrelieved shortness of breath / SOB while at rest<br><input type="checkbox"/> Unrelieved chest pain<br><input type="checkbox"/> Wheezing or chest tightness at rest<br><input type="checkbox"/> Need to sit in a chair to sleep<br><input type="checkbox"/> Weight gain or loss of more than 5 Lbs. in 2 days<br><input type="checkbox"/> Confusion | <ul style="list-style-type: none"><li>• Needs immediate or urgent evaluation by a physician.</li></ul>   |