HF Weekly Follow-Up Call Script

| Pt. Name: _____________________ | Date: _____________________ | Phone: _______________
| Interviewer: __________________ | Physician: __________________ | (*=Needs Intervention)
| Time of Call: __________________ | Call #: ____________________ | YES | NO |

**WEIGHT**
1. Are you keeping a daily weight log? ☐ ☐*  
2. If you gain 2-3 lbs overnight, or 5 lbs, in 5 days do you know what to do? ☐ ☐*  

**MEDICATIONS**
3. Have you been taking the medications as your doctor ordered? ☐ ☐*  
   Please get your meds and tell me what you are taking.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

4. Have you had any medication changes since you have been in the hospital? ☐ ☐  
   Please list them__________________________________________________

5. Have you ever missed a dose or run out of your medications? ☐* ☐  
   Do you experience any major side effects from your medications? ☐* ☐  

**DIET/EXERCISE**
6. Do you understand your low sodium diet? ☐ ☐*  
   Tell me what you ate in the last 24 hours:
   Breakfast___________________________________________________
   Lunch______________________________________________________
   Dinner_____________________________________________________
   Snacks______________________________________________________
   Do you exercise regularly? _______Minutes________ #times per week

**SIGNS/SYMPTOMS**
7. Have you had any swelling in your ankles/abdomen? How much? _________ ☐* ☐  
8. Since we spoke last, have you had any trouble with:
   - **Chest Pain** ☐* ☐  
   - Palpitations/Fluttering in chest ☐* ☐  
   - Coughing_____ dry_______ productive ☐* ☐  
   - Shortness of breath with exertion ☐* ☐  
   - **Shortness of breath at rest** ☐* ☐  
   - (How far can you walk before you become SOB?)
   - **Sudden shortness of breath, waking you up from sleep** ☐* ☐  
   - (How many pillows do you sleep on at night?)_____

9. Can you perform your ADL’s without becoming SOB, tired, or weak? ☐ ☐*  
10. Have you experienced weakness, faintness, and dizziness? ☐* ☐  
    Do you have any other significant complaints you would like to mention? ☐* ☐
11. Have you been to the ER/hospital since we last spoke? ☐* ☐  
12. When is your next appointment with your MD? _______________________

Highlighted responses: Instruct patient to call MD ASAP
If two or more positive responses, needs intervention (call MD)

Recommendations: Teaching implemented: Medications_____ Wt. Monitoring____ Diet ____ MDF/U____
CHF S/S____

Comments: ________________________________________________

Education Materials Sent:

Source: Advisory Board interviews and analysis.