PARTNERS MEDICAL CLINIC

Partnership in Healthcare

Heart Failure Patient Education Checklist

Patient Name: _____

Date of Birth: _____ Chart Number: _____

Weight Monitoring Date (s): _____

_____

Sodium Restriction Date (s): _____

_____

Physical Activity Date (s): _____

_____

Smoking Cessation* Date (s): _____

_____

Minimizing/Avoiding NSAID use Date (s): _____

_____

Referral for Education/Management Programs Date (s): _____

_____

Prognosis/End-of-Life Issues Date (s): _____

_____

Medication Instruction Date (s): _____

_____

Symptom Management Date (s): _____

_____

*Circle if patient is a non-smoker