Advanced Heart Failure Diagnostic Checklist

- Suspect
- Screen
- Labs
- Treat
- Refer

Open a new world for your advanced heart failure patients

HeartMate II
Left Ventricular Assist System
### ADVANCED HEART FAILURE DIAGNOSTIC CHECKLIST:

Recommendations for advanced heart failure management continue to evolve as technologies and outcomes improve. These simple checklists provide clinicians with defined tools for identifying patients who may benefit from Mechanical Circulatory Support.  

Being aware of these checklists enables clinicians to refer patients in a timely fashion; studies indicate that referral before a patient deteriorates to end-organ damage or nutritional deficiency can maximize the benefit of advanced interventions.

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#### Signs and Symptoms of Advanced Heart Failure
- Dizziness/lightheadedness
- Dyspnea
- Edema/swelling
- Exercise intolerance
- HR < 60/min or > 120/min
- Chest pain
- Loss of appetite
- Nausea/vomiting
- Orthopnea
- Palpitations
- Paroxysmal nocturnal dyspnea
- Profound fatigue
- Restlessness, confusion or fainting
- Severe cough
- Weight loss
- Wheezing

#### Lab Assessment

**BNP/NT-pro BNP**
- **LFTs**
- **Prothrombin PT/INR**
- **Transferrin**
- **TSH, T3, T4**
- **Urine analysis**

#### Rx

- **ACE inhibitors**
- **ARBs**
- **Aspirin therapy**
- **Beta-blockers**
- **Digoxin**
- **Diuretics**
- **Nitroprusside**
- **Inotropes**
- **Warfarin**

#### Indications for Referral

- CRT non-responder
- High diuretic dose (≥120 mg/dose furosemide)
- Inability to walk one block without shortness of breath
- Currently on or considering inotropes
- LVEF < 35%
- Intolerant/withdrawal of oral agents
- Intolerant to ACE inhibitors, ARB or beta-blockers
- NYHA class III/IV heart failure symptoms
- One heart failure-related hospital admission in the past 6 months

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### Patient Information

- **Patient Name:**
- **Medical Record #:**
- **Referring Physician:**
- **Assessment Taken By:**

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### Evaluation

- **Advanced Heart Failure:**
- **HeartMate II:**
- **Shared Care™:**
- **Preferred Contact Method:**

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### Referral Form

- **Patient Name:**
- **Medical Record #:**
- **Referring Physician:**
- **Preferred Contact Method:**

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### Laboratory Assessment

- **BUN > 40mL/dl at serum or sodium creatinine > 1.8mg/dL**
- **Hematocrit < 35%**
- **Serum sodium < 136 mmol/L**
References

## Contact List

### THORATEC REPRESENTATIVE

Rep Name: __________________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

### REFERRING CARDIOLOGY PRACTICE

Specialist Name: ____________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

### IMPLANTING CENTERS

Center Name: ________________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

Center Name: ________________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

Center Name: ________________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

### SHARED CARE SITES

Center Name: ________________________________________________________________________________________

Contact Person: ____________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

### PATIENT MENTORS

Name: ____________________________________________________________________________________________

Phone#: (_______) E-mail: __________________________________________________________________________

Address: _________________________________________________________________________________________

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**Business Card**

(pocket)

www.HeartMatePro.com