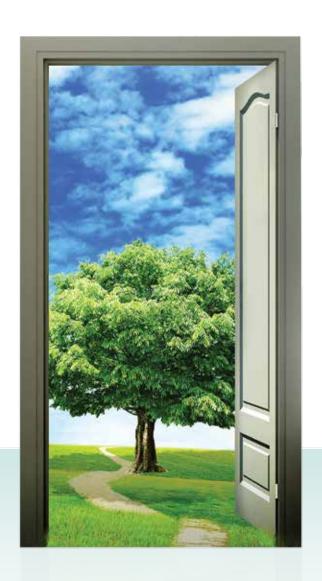
Advanced Heart Failure Diagnostic Checklist



Open a new world for your advanced heart failure patients





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.²

Advanced Heart Failure dizziness/lightheadedness chest pain palpitations paroxysmal noctonral dyspnea weigh weigh	re cough
Date Completed: Date C	
To Include: BUN/creatine, sodium, potassium, cloride, CO2, GFR Date Completed: Date Compl	HA FC class IIIB/IV inosis Completed:
	Completed: , T3 , T4 Completed:
	inotropes Dose:
INDICATIONS FOR REFERRAL ☐ CRT non-responder ☐ high diuretic dose ☐ high diuretic dose ☐ (≥120 mg/dose furosemide) ☐ intolerant/withdrawal of oral agents ☐ intolerant to ACE inhibitors, ARB or beta-blockers ☐ NYHA class III/IV heart failure symptoms ☐ currently on or considering inotropes ☐ IVEF <35% ☐ intolerant/withdrawal of oral agents ☐ BUN >40mL/dL at ser creatinine > 1.8mg/dL ☐ hematocrit <35% ☐ serum sodium <136 mm ☐ one heart failure-related hospital admission in the past 6 months²	JL
Physician Name: Office Phone#: (BMI: kg/m²

References 1. Russell SD1, Miller LW, Pagani FD. Advanced heart failure: a cal Continuous-Flow Left Ventricular Assist Device Patients Stratified by P	l to action. <i>Congest Heart Fail</i> . 2008 Nore-Operative INTERMACS Classification	ov-Dec;14(6):316-21. 2. Boyle AJ, Ascheim . <i>JHLT</i> 2011; 30: 402-7.	DD, et al. Clinical Outcomes for
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Contact List

Rep Name:		
	E-mail:	
REFERRING CARDIOLOGY P	ACTICE	
Specialist Name:		
Phone#: ()	E-mail:	
IMPLANTING CENTERS		
Center Name:		
	E-mail:	
Phone#: ()	E-mail:	
Phone#: ()		
Phone#: () Center Name: Phone#: ()		

SHARED CARE SITES

Center Name:
Contact Person:
Phone#: ()
E-mail:
DATIENT MENTODS
PATIENT MENTORS
PATIENT MENTORS Name:
Name:
Name:
Name:

Business Card

(pocket)

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