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.[1] 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]

☑ Please Check Box if Included in Referral

SUSPECT

Signs and Symptoms of Advanced Heart Failure

- ❑ dizziness/lightheadedness
- ❑ dyspnea
- ❑ edema/swelling
- ❑ exercise intolerance
- ❑ HR <60/min >120/min
- ❑ chest pain
- ❑ loss of appetite
- ❑ nausea/vomiting
- ❑ orthopnea
- ❑ palpitations
- ❑ paroxysmal noctonral dyspnea
- ❑ profound fatigue
- ❑ restlessness, confusion or fainting
- ❑ severe cough
- ❑ weight loss
- ❑ wheezing

SCREEN

- ❑ 12-lead ECG
  *Date Completed:*_____
- ❑ 6 minute walk distance
  (CPT Code: 03306 / 93018)
  Meters Walked: _____
  *Date Completed:*_____
- ❑ carotid doppler
  *Date Completed:*_____
- ❑ CPX/VO2 + RER
  (CPT Code: 94680)
  *Date Completed:*_____
- ❑ CXR
  *Date Completed:*_____
- ❑ ECHO 2D/M mode
  (CPT Code: 93306)
  *Date Completed:*_____
- ❑ NYHA FC class IIIB/IV diagnosis
  *Date Completed:*_____

LABS

- ❑ Metabolic Panel
  To Include: BUN/creatine, sodium, potassium, cloride, CO2, GFR
  *Date Completed:*_____
- ❑ blood type_____
  *Date Completed:*_____
- ❑ BNP/NT-pro BNP
  *Date Completed:*_____
- ❑ hemoglobin A1C
  *Date Completed:*_____
- ❑ iron level
  *Date Completed:*_____
- ❑ LFTs
  *Date Completed:*_____
- ❑ prealbumin
  *Date Completed:*_____
- ❑ prothrombin PT/INR
  *Date Completed:*_____
- ❑ transferrin
  *Date Completed:*_____
- ❑ TSH, T3, T4
  *Date Completed:*_____
- ❑ urine analysis
  *Date Completed:*_____

TREAT

- ❑ ACE inhibitors
  *Medication:*_____
  Dose: _____
- ❑ ARBs
  *Medication:*_____
  Dose: _____
- ❑ aspirin therapy
  Dose: _____
- ❑ beta-blockers
  *Medication:*_____
  Dose: _____
- ❑ digoxin
  Dose: _____
- ❑ diuretics
  *Medication:*_____
  Dose: _____
- ❑ nitrates
  *Medication:*_____
  Dose: _____
- ❑ warfarin
  Dose: _____
- ❑ inotropes
  Dose: _____

REFER

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[2]

LAB ASSESSMENT

- ❑ BUN >40mL/dL at serum or sodium creatinine >1.8mg/dL
- ❑ hematocrit <35%
- ❑ serum sodium <136 mmol/L

EVALUATE

- ❑ **Advanced Heart Failure**
- ❑ **HeartMate II**

Shared Care™:

- ❑ **Yes**
- ❑ **No**

Physician Name:_____

Office Phone#: (_____)_____

Cell Phone#: (_____) _____

E-Mail:_____

Fax#:_____

Practice Name: _____

Preferred Contact Method:

❑ CELL ❑ LETTER ❑ TEXT ❑ E-MAIL ❑ FAX

Patient Name: _____

Medical Record#:_____

Gender: ❑ M ❑ F

Date of Birth: ___ / ___ /____ Age:_____ BMI: _____ kg/m²

Patient Phone#: (_____) _____

Patient E-mail:_____

Referring Physician: _____

Assessment Taken By: _____

References

1. Russell SD1, Miller LW, Pagani FD. Advanced heart failure: a call to action. *Congest Heart Fail.* 2008 Nov-Dec;14(6):316-21. **2.** Boyle AJ, Ascheim DD, et al. Clinical Outcomes for Continuous-Flow Left Ventricular Assist Device Patients Stratified by Pre-Operative INTERMACS Classification. *JHLT* 2011; 30: 402-7.

www.HeartMatePro.com

THORATEC® CORPORATION *for Life*

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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: _____

_____

Business Card

(pocket)

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