HEART FAILURE ACTION PLAN

Name: _____

Medical Provider's	Clinical Case Manager's
Name: _____	Name: _____
Phone: _____	Phone: _____

THINGS TO DO EVERYDAY FOR MY HEART:

- ☐ Take my medicines as directed
- ☐ Weigh myself at the same time and in the same way (i.e., in the morning, wearing pajamas) and write the number down on my calendar
- ☐ Follow my eating and activity/exercise plan

THINGS TO AVOID:

- ☐ Adding salt to my diet
- ☐ Eating foods high in salt
- ☐ Smoking or using tobacco products
- ☐ Stress
- ☐ Sick people

I WILL DISCUSS WITH MY MEDICAL PROVIDER:

- ☐ Salt restriction
- ☐ Activity/Exercise
- ☐ Yearly Flu vaccine
- ☐ Pneumonia vaccine
- ☐ Liquid intake/day
- ☐ Other diet restrictions (including caffeine and fats)
- ☐ Cardiac Echo (a test to check how well your heart pumps)
- ☐ Whether other medicines for my heart, ACEI/ARB and Beta Blocker are needed
- ☐ Take _____pill if I gain_____pounds in a day or _____pounds in a week or call the medical provider if he/she tells me to call

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My LDL Cholesterol:	My Goal:

I WILL CALL 911 IF:

- ☐ I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea that does not go away with rest or after taking my medicine.

I WILL CALL MY MEDICAL PROVIDER TODAY IF:

- ☐ I have new swelling in my feet, ankles or hands or if my swelling has gotten worse
- ☐ I have gained_____pounds in a day or _____pounds in a week
- ☐ I feel like my heart is racing or pounding
- ☐ I have new shortness of breath or it is getting worse
- ☐ I have a cough with mucus and/or a fever
- ☐ I am unable to sleep lying down flat
- ☐ I have light-headedness

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MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)	Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important 1 2 3 4 5 6 7 8 9 10 Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):