

23-Apr-07 00:00 Heart Failure Resource Center  
PIEDMONT HOSPITAL  
FUQUA HEART FAILURE RESOURCE CENTER  
Initial Clinic Visit  
4/23/2007

PATIENT NAME: Sample Admission Note

DOB:

REASON FOR CONSULTATION: Heart Failure

CHIEF COMPLAINT: SOB at rest, Abdominal bloating, Nausea and vomiting.

cc: XXX., MD

HISTORY OF PRESENT ILLNESS: This 28 year old Caucasian male patient with heart failure has been sent by Dr to the Heart Failure Resource Center for consultation including comprehensive evaluation, medication optimization, monitoring and education. He presented to Dr. s office this morning with complaints of worsening abdominal bloating, nausea, fatigue and SOB. He was brought over in a wheelchair. He has a history of a MI in 2004, ICD placement in 11/2004 for ventricular tachycardia, and a noncompaction cardiomyopathy with EF 15-20% by echocardiogram 7/2006. He also is HIV positive but has never been on antiretroviral therapy. He has had multiple hospitalizations for heart failure that typically present with abdominal bloating, nausea & vomiting, fatigue and SOB. He was just discharged from Piedmont on Thursday of last week after a six day hospitalization for heart failure. He presents today with complaints of worsening abdominal bloating, nausea and dry heaves, fatigue, cough and SOB at rest. His reported weight at hospital discharge was 162lbs. compared to his weight today in HFRC of 170.3lbs. fully dressed. He reports a positive response to his daily Lasix 80mg. He complains of a persistent dry cough that he has had for several months. He denies PND, orthopnea or leg swelling. He appears to be taking his other heart failure medications as instructed including Lisinopril, Coreg, Aldactone, Imdur, Digoxin and Coumadin.

PAST MEDICAL HISTORY:

Heart Failure

- a. Non-compaction cardiomyopathy, EF 15-20% by echocardiogram 7-13-2006.

S/P MI - 10/2004

ICD - 11/2004

Ventricular Arrhythmias

- a. episode of Ventricular Tachycardia

Renal insufficiency/failure

- a. Creatinine high 2.2

Human immunodeficiency virus

a. No antiretroviral treatment  
Hepatitis B

**CARDIAC RISK FACTORS:** Negative for hyperlipidemia, hypertension, diabetes, obesity or smoking history.

**SOCIAL HISTORY:** The patient is single. He is working. He has been on medical leave from his job as a property manager due to his recent hospitalizations. He does not smoke. He does not drink alcohol. He does not use illicit drugs. Patient does not exercise regularly.

**ADVANCED DIRECTIVES:** Patient has not executed an Advance Directive at this time.

**FAMILY HISTORY:** Mother with heart disease and hypertension. He does not know if his father has any medical problems.

**ALLERGIES:** NKA.

**CURRENT MEDICATIONS:**

Lisinopril (Prinivil) 5mg Daily  
Carvedilol (Coreg) 12.5mg BID  
Spironolactone (Aldactone) 25mg Daily  
Furosemide (Lasix) 80mg Daily  
Isosorbide mononitrate (Imdur) 30mg Daily  
Digoxin (Lanoxin, Digitek) 0.125mg Daily  
Warfarin (Coumadin) as directed by CDS  
Neurontin 300mg BID

**REVIEW OF SYSTEMS:**

**GENERAL:** Denies weight loss, fevers. Complaining of weight gain, weakness, fatigue. His reported weight at hospital discharge on 4-19-07 was 162lbs. and his clinic weight today is 170lbs, which is an approximate 8 lb. gain in 4 days.

**INTEGUMENTARY:** Skin Intact. Denies lesions, leg swelling, rashes, ulcers.

**HEENT:** He does not wear glasses or contacts. Denies headaches, change in hearing, dry mouth, bleeding gums, changes in vision, nose bleeds.

**CARDIOVASCULAR:** Sleeps on 2 pillows. Denies chest pain or discomfort, waking up at night with SOB, palpitations.

**RESPIRATORY:** Complaining of Productive cough, shortness of breath at rest. He is complaining of a dry hacking nonproductive cough that he has had for several months. He is also complaining of SOB at rest that worsens with any activity.

**GI:** Denies changes in appetite, blood in stools, abdominal pain, heartburn, changes in bowel movements. Complaining of abdominal swelling, nausea, vomiting. He is complaining of nausea with dry heaving, no emesis. He reports that his abdomen feels more bloated than at hospital discharge.

GU: Patient reports a positive urinary response from current diuretic therapy. Denies pain with urination, frequent urination at night, blood in urine, incontinence. He reports a positive urinary response from his Lasix but states that it is less than he was having while in the hospital.

MUSCULOSKELETAL: Denies atrophy, weakness, pain in joints, calf pain with walking. Complaining of limitations with mobility. His mobility is limited by his extreme fatigue and SOB.

NEUROLOGIC: Denies seizures, numbness, fainting spells. Complaining of dizziness. He reports that he is dizzy most of the time and it worsens with movement.

ENDOCRINE: Denies heat or cold intolerance.

HEMATOLOGIC: Denies easy bleeding, past transfusions, anemia. Complaining of easy bruising. He complains of bruising easily secondary to Coumadin therapy.

#### PHYSICAL EXAMINATION:

GENERAL: Patient is alert, oriented. Anxious, dyspneic with conversation. Motor response is grossly intact. Patient is in a wheelchair. Mr. was brought over in a wheelchair from Dr. 's office because he was too weak to walk.

VITAL SIGNS: Height 6'2". Temp 98.7. BP 97/65 left arm Pulse 106. Telemetry shows Sinus Tachycardia with rare PVC. Resp 22. O2 sat 98% room air. Weight 170.3 lbs in clinic. Weight gain of 8 lbs over 4 days.

EYES: Conjunctivae and sclera clear.

SKIN: Skin is warm, dry.

NECK: Jugular venous pressure of 6-9cm noted. Neck veins difficult to visualize. No carotid bruits.

LUNGS: Respirations labored. Lung sounds are clear.

CARDIAC: S1, S2, regular rate and rhythm. No murmur, rub or gallop. No carotid bruits. Peripheral pulses: Left radial 2+ Right radial 2+

ABDOMEN: Non-tender, firm, distended. Bowel sounds present in 4 quadrants.

EXTREMITIES: No clubbing or cyanosis. Capillary refill is quick. No edema noted in lower extremities.

PAIN: Patient not complaining of pain at this time.

#### DATA:

7/13/2006 - Echocardiogram - Left ventricular chamber size is severely dilated. The wall is thickened with deep trabeculations consistent with a noncompaction cardiomyopathy. There is severely decreased left ventricular systolic function. The EF appears to be 15-20%. The left atrium is mildly to moderately dilated. The right ventricular chamber size and systolic function are within normal limits. The right ventricular systolic pressure is estimated to be 50-60mmHg, indicating moderate pulmonary hypertension.

MINNESOTA LIVING WITH HEART FAILURE QUESTIONNAIRE: Total score of 105/105 indicating significant physical, emotional and socioeconomic effects from his heart failure.

SLEEP APNEA SCREENING: Sleep apnea screening positive for hypertension with a total score of 2 suggesting low probability of sleep apnea.

PATIENT HEART FAILURE KNOWLEDGE SELF ASSESSMENT: Patient scored 90% on the Patient Self Assessment. Patient has a basic understanding of heart failure symptoms and treatment strategies.

IMPRESSION:

1. Mildly decompensated heart failure NYHA Class III-IV, Stage C with worsening symptoms of nausea/vomiting, weakness and SOB at rest.
2. Noncompaction cardiomyopathy, EF 15-20% by echocardiogram 7-13-2006.
3. Status post MI 10/2004.
4. Status post implantable cardioverter-defibrillator placement 11/2004 due to episode of ventricular tachycardia. .
5. Co-morbidities include HIV, Renal insufficiency, Hepatitis B.

PLAN:

Check labwork to evaluate Electrolytes, Blood Count, Renal Function, BNP.

Results: Na 134, K+ 4.7, H/H 15.0/44, Creatinine 1.2, BNP 1500.

Optimization of heart failure medications to improve heart failure symptoms per Fuqua HFRC protocols. The following changes will be implemented:

- A. Suspect that his cough may be from his ACE-I. Will switch him to Cozaar 12.5mg Daily and have him take it at night.
- B. Increase Coreg to 25mg BID due to his tachycardia with HR 106bpm. Will monitor his blood pressure closely via remote nurse telemonitor. May consider switching to Toprol XL if blood pressure remains a problem.
- C. Lasix 80mg IVP given per protocol for extra fluid volume with NYHA Class IV symptoms. Patient had a positive urinary response prior to leaving the HFRC. Will consider adding Zaroxolyn 5mg to his diuretic regimen if needed to diurese him to a weight of <160lbs.
- D. Continue Imdur 30mg Daily. Hydralazine was stopped due to low blood pressure.
- E. Continue Digoxin 0.125mg Daily. Check Digoxin level at next visit.
- F. Continue Coumadin as directed by CDS.G. Discourage use of non-steroidal anti-inflammatories for pain due to both their potential antagonist effects and increased risk of nephrotoxicity with diuretics and ACE therapy. Recommended Tylenol only for pain relief.

Encouraged adherence with 2 gram sodium and 2000 ml fluid restricted diet.

Provided explanation, etiology, and symptoms of heart failure. Reviewed signs and symptoms of HF: SOB, DOE, PND, Swelling, Weight Gain, Fatigue.

Enroll in heart failure Community Telemanagement Program for daily monitoring of heart failure symptoms, weights, HR, BP. Instruct patient to call HFRC if weight increases more than 3 lbs in 24 hrs or 5 lbs in a week.

Will monitor his compliance and fluid volume status and be available to intervene with outpatient diuretic therapy if needed.

Return to HFRC for follow up in 1 week. or sooner if he develops worsening heart failure symptoms.

**RECOMMENDATIONS:**

Consider echo with Tissue Doppler Imaging (TDI) to assess cardiac dysynchrony and potential benefit from CRT. Patient may meet Companion (EF < 35%, NYHA class III, QRS > 120ms) criteria for CRT-D. QRS on EKG on 4/15/2007 was 124ms.

Documented by: RN, MSN, CCNS

Signed by: RN, MS, NP-C

Date of Service: 4/23/2007

SAMPLE