

Success Heart Failure Discharge Plan

for _____
FIRST LAST



My next follow-up visit is:

DATE

at

TIME

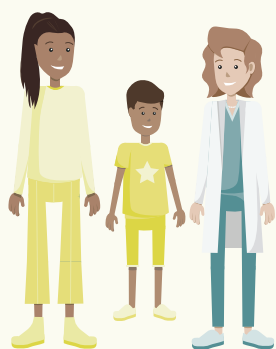
with

CARE PROVIDER

at

LOCATION

My care team can be reached at:



Your heart medicines may change often. At your next visit, **ask your care team** if any of your medicine doses need to change.

I am on the following types of heart medicine:

- ACE/ARB/ARNI: _____
- Beta Blocker: _____
- Aldosterone Antagonist: _____
- Diuretic: _____
- Heart Rhythm: _____
- Other: _____

Please see the **discharge summary** for exact dose of each heart failure medicine your child should be taking.

My vital signs at discharge:



Blood Pressure:

Oxygen Saturation:

Heart Rate:

Weight:

_____ lbs

_____ kg



My activity and diet:

My care team recommends a: Normal diet



Restricted diet: _____

My feeding plan is: _____



My fluid intake goal is: Normal intake

Set by my care team as follows:

Daily Minimum: _____ Daily Maximum: _____

My physical activity is: Not restricted



Restricted: _____

Success Heart Failure Discharge Plan

for

FIRST

LAST

action

ADVANCED CARDIAC THERAPIES
IMPROVING OUTCOMES NETWORK

For children between the ages of 1–18, use the zones below as a guide to monitor your child after discharge and as a reference for when to contact your care team. **In case of emergency, call 911.**



GREEN ZONE

Your child is doing great!

My child has:

- No trouble breathing, or breathing is normal for my child
- Ability to continue their normal activity
- No swelling in their face, eyelids, legs, feet, or stomach
- No trouble with eating, and has their normal appetite
- Weight is within goal range

What to do: Continue current plan.



YELLOW ZONE

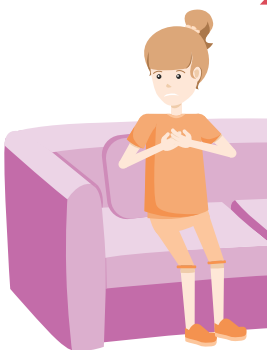
Your child may have worsening heart failure.

My child has:

- Shortness of breath, especially with physical activity
- Weight: gained ____ lbs in ____ days OR lost ____ lbs in ____ days
- Increased fatigue (tiredness), need to take a more than normal amount of breaks while playing or exercising
- Mild swelling in their face, eyes, legs, feet, or stomach
- Difficulty lying down or sleeping flat
- Nausea/vomiting or poor appetite

What to do: (check all that apply)

- Make the following changes to your diuretic medicine: _____
- Call your care team for further advice.



RED ZONE

Your child has concerning signs of heart failure, requiring evaluation.

My child has:

- Rapid breathing, faster than normal even when sitting or resting
- A lot of swelling in their face, eyelids, legs, feet, or abdomen
- Nausea, vomiting, complaints of abdominal pain, especially after eating
- Continued weight gain, or weight gain more than ____ lbs in ____ days
- Continued weight loss, or weight loss more than ____ lbs in ____ days
- No relief of symptoms after using the extra diuretics in yellow zone for ____ days

What to do: Call your care team for further advice.