☐ CHM ☐ RIM
☐ DRH ☐ SGH
☐ HWH ☐ TCH
☐ HUH ☐ MIOSH
☐ HVSH

Detroit Medical Center
Wayne State University

230

PATIENT DISCHARGE INSTRUCTION RECORD: Myocardial Infarction/Acute Coronary Syndrome

(Circle One)

Discharge Date _____

Appointments and Plan for Continued Care:

Physician/Clinic _____ Date_____ Phone_____
Physician/Clinic _____ Date_____ Phone_____
Physician/Clinic _____ Date_____ Phone_____

Comments: _____

ACTIVITIES: ☐ Resume usual activitiesLimitations: ☐ No driving until after first follow-up visit with physician. ☐ No lifting ☐ Alternate activity periods with rest periods; break up large activities into smaller tasks. ☐ Stop any activity at the first sign of chest pain, heaviness or tightness or increased shortness of breath. ☐ Avoid sexual activity until after first follow-up visit with physician. ☐ No bending/twisting at waist. ☐ Return to Work/School: _____

DIET: ☐ Low Sodium ☐ Low Saturated Fat ☐ Diabetic ADA _____ calories ☐ Other _____
☐ Special Instructions _____

REFERRALS FOR CONTINUED CARE:

☐ Home Care Agency/Phone _____ Date of 1st visit _____
☐ Equipment Supplier/Phone _____ Delivery Date _____
DMC REFERRAL SERVICES 1-888 DMC 2500 (1-888-362-2500)
☐ Site: _____Cardiac Rehab Resources _____ ☐ Declined _____
☐ Site: _____Smoking Cessation Program _____ ☐ Declined ☐ NA _____
☐ Site: _____Diabetic Education Program _____ ☐ Declined ☐ NA _____

PERSONAL RISK FACTORS:

a. My Total Cholesterol (TC) = _____ (Goal less than 200) Low Density Cholesterol (LDL) = _____ (Goal less than 100)
High Density Cholesterol (HDL) = _____ (Goal greater than 40) Heart Function Ejection Fraction (EF) _____%
b. Tobacco Use: ☐ No ☐ Yes ☐ Smoking counseling provided ☐ Medication prescribed _____
c. Pneumococcal Vaccine: ☐ No Why?_____ ☐ Yes Date_____
d. Influenza Vaccine: ☐ NA (Apr - Sept) ☐ No Why? _____ ☐ Yes Date_____

Notify Physician Immediately for any of the following symptoms:

- Fever above 100.4 or _____
- Heaviness in the chest, palpitations.
- Take your pulse and if greater than 100 or less than 50, you become light-headed, weak, or sweaty.
- You become sweaty, nauseated, light-headed or dizzy after taking medicines.
- If you are on blood thinners and you start bleeding in your urine, stool, or from nose or gums.
- Ankles or legs begin to swell or weight gain of more than _____ pounds per week ☐ Renal Failure _____ pounds per day.
- Call 911 if sudden chest pain unrelieved by medication, lasting longer than 15 minutes or shortness of breath.

IF YOU HAVE ANY FURTHER QUESTIONS, CONTACT YOUR PHYSICIAN OR CLINIC

DISCHARGE MEDICATIONS **Inform your Primary Health Care Provider if you are taking:**
• Vitamins • Over the counter medications • Herbal Supplements • Other medications not listed below
Please note the following: How often Route: PO = By mouth PR = By rectum TF = Tube feeding
Once a day BID = Twice a day TID = Three times a day Subcut = Under the skin, fatty layer
QID = Four times a day PRN = As needed HS = Bedtime SL = Under the tongue IM = Into the muscle

MEDICATION/DOSE	How to take	Times a day	Reason for medication	Next dose due
Aspirin				
Beta Blocker				
ACE Inhibitor				
Statin				

DO NOT TAKE: Circle and state reason for not taking one of the following drugs: Aspirin _____
Statin _____ Beta Blocker _____ Ace Inhibitor _____

Physician Signature _____ Date _____

RN TO COMPLETE THIS SECTION

EDUCATION NEEDS ASSESSED AND PROVIDED: (check those that apply):
☐ Myocardial Infarction/Acute Coronary Syndrome Health Maintenance Agreement given

Health Care Resources (check those that apply)
☐ Exercise (Cardiac Rehab) ☐ Smoking Cessation ☐ Weight Monitoring ☐ Diet ☐ Cholesterol Guidelines ☐ Medications
☐ Food Drug Interactions ☐ Pain Management Worsening Signs & Symptoms ☐ Myocardial Infarction ☐ Angina
☐ Other: _____

I have received and understand my discharge instructions:

_____ Date _____
Signature of patient or responsible party (Parent or guardian if patient is a minor)

DISCHARGE STATUS

Discharged to: ☐ Home ☐ Other: _____

Accompanied by: _____

If patient is minor, identity of parent/guardian is verified ☐ Yes

_____ Date _____
Signature of RN Completing Discharge

Please bring a copy of this instruction sheet with you to your physician on your follow up visit

☐ CHM ☐ RIM
☐ DRH ☐ SGH
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- Heaviness in the chest, palpitations.
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- You become sweaty, nauseated, light-headed or dizzy after taking medicines.
- If you are on blood thinners and you start bleeding in your urine, stool, or from nose or gums.
- Ankles or legs begin to swell or weight gain of more than _____ pounds per week ☐ Renal Failure _____ pounds per day.
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ACE Inhibitor				
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Discharged to: ☐ Home ☐ Other: _____

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_____ Date _____
Signature of RN Completing Discharge

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