

Berkshire Medical Center

Cardiovascular Disease Checklist

Identify Circle all appropriate Primary and Secondary Diagnoses

Patient Sticker

QM / CM Reviewer _____

Updated 1/9/02

	CAD	A fib	AMI/UA	CHF	Stroke	PVD	DM	CAP	
Flu Vaccine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Pneumovax	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
BMI kg/m²	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Wt. _____ kg _____ BMI _____
BP at disch. <140/90	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	130/85 <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	130/80 <input type="radio"/>	<input type="radio"/>	BP @ discharge _____
Smoking Cessation									Date _____ Time _____ Initials _____
Documented ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Plan _____
Lipid Management									LDL _____ Date _____
Lipid Profile ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Treatment ?	? Cl: (circle) Abnormal LFT's, allergy, other _____								D/C Tx _____
B blocker									Date _____ Time _____ Initials _____
Admit ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tx _____
Discharge ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
	? Cl: (circle) Allergy, HR<60, shock, SBP<100, 2° or 3° heartblock, bronchospasm, other _____								D/C Tx _____
ACE									Date _____ Time _____ Initials _____
Admit ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tx _____
Discharge ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
	? Cl: (circle) Allergy, aortic stenosis, Cr>2, SBP<100, other _____								D/C Tx _____
ASA									Date _____ Time _____ Initials _____
Admit?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tx _____
Discharge ?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
	? Cl: (circle) Warfarin , allergy, bleeding/hx of bleeding, chronic liver disease, platelets < 100K, H/H<10/30, hx PUD, Cr >3, other _____								D/C Tx _____
Warfarin (complete list of ? Cl on reverse)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Plavix			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Rehab			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Ejection Fraction			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Cardiac Rehab	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Spironolactone			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Digoxin		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Diuretics			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Discharge Teaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Acute Thrombolytic Given?			Y / N		Y / N				Date _____ Time _____ Initials _____
Hgb A1C									Date _____ Time _____ Initials _____
U/A for Microalbumin if Dipstick Tr or Neg.									Date _____ Time _____ Initials _____
Oxygenation assessed							<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Blood Cultures before antibiotics							<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Abx w/in 8 hrs							<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____
Switch IV to PO							<input type="radio"/>	<input type="radio"/>	Date _____ Time _____ Initials _____

Home on Switch day



Date _____ Time _____ Initials _____

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