



Patient: _____ was admitted to the Cardiology Service
 at the _____ from Y ____ /M ____ /D ____
 to Y ____ / M ____ / D ____ under the care of Dr. _____.

Discharge Diagnoses include:

- CAD-CCS Class: 0 1 2 3 4
- Unstable angina
- Non STEMI (non-ST elevation MI)
- STEMI (ST elevation MI)
- Atrial fibrillation
- SVT
- VT
- CHF-NYHA Class: I II III IV
- Other: _____

Risk Factors:

- HTN DM Dyslipidemia Smoking Family History CAD

Past Medical History:

- Angina MI PCI CABG Valve Replacement
- Other: _____

Complications:

- Recurrent ischaemia
- CHF-Killip Class ____ / IV
- Pericarditis
- DVT/ Pulmonary embolism
- Heart Block: 1° 2° WB/MB II 3°
- Temporary Pacer Insertion Y/N
- LV thrombus
- Mechanical complication
 - MR
 - Aneurysm
 - Septal rupture
- Atrial fibrillation
- Ventricular tachycardia
- Other: _____

Pertinent Investigations:

Peak CK _____ CK MB _____ Troponin I/T _____ Other: _____

Total cholesterol: (target value mmol/L)

LDL ____ (<4.5) TG ____ (<1.7) HDL ____ (>1.2) LDL ____ (<2.0)

Stress Test:

Ex duration ____ Peak HR ____ (% PMHR ____) Positive Y/N High Risk Y/N

Echocardiogram EF ____ % LV Function: _____

Valves: _____



DISCHARGE SUMMARY

MEDICATION PRESCRIPTIONS

✓	Class	Indication	Specific Rx	Dose (mg) & Frequency	Amount	Refills
	Nitroglycerin SL	Angina treatment				
	ASA	Blood thinner				
	Plavix	Blood thinner				
	β-blocker	<input type="radio"/> Angina <input type="radio"/> LV function/prognosis				
	Nitrate	Angina prevention				
	Calcium blocker	<input type="radio"/> Angina <input type="radio"/> HTN				
	Digoxin	<input type="radio"/> Atrial fib <input type="radio"/> CHF				
	Diuretic 1	Fluid retention				
	Diuretic 2	Fluid retention				
	Diuretic 3	Fluid retention				
	ACE inhibitor	LV function/prognosis				
	A-II antagonist	LV function/prognosis				
	Statin	Cholesterol lowering				
	Fibrate	Cholesterol lowering				
	Niacin	Cholesterol lowering				
	Ezetimibe	Cholesterol lowering				
	Anti-platelet	Blood thinner				
	Coumadin	Blood thinner				
	Anti-arrhythmic	<input type="radio"/> Atrial fib <input type="radio"/> VT				
	Oral Hypoglycemic	Blood sugar control				
	Oral Hypoglycemic	Blood sugar control				
	Oral Hypoglycemic	Blood sugar control				
	Insulin AM	Blood sugar control				
	Insulin PM	Blood sugar control				
	Other:					
Signature (physician)		Name printed		CPSO #:	Phone #:	

Supplementary Prescriptions/Discharge Rx:

✓	Rx	Indication	Specific Rx	Dose (mg) & Frequency	Amount	Refills
Signature (physician)		Name printed		CPSO #:	Phone #:	

CARDIOVASCULAR RISK REDUCTION CHECKLIST

Rx ✓	Intervention	Recommendations															
	Smoking: Goal -Complete cessation	Strongly encourage patient and family to stop smoking. Provide counselling, nicotine replacement, and formal cessation programs as appropriate.															
	Lipid Management: Primary goal * LDL < 2.0 (1.8) mmol/L	Start hypolipidemic diet in all patients: ≤ 30% fat, < 7% saturated fat, < 200mg/day cholesterol. 10% LDL ↓ achievable with diet. Assess fasting lipid profile. Baseline lipid profile < 24 hrs. after acute event. In post-MI patients, lipid profile may take 4 to 6 weeks to stabilize. Add drug therapy according to the following guide:															
	Secondary goal * TC/HDL < 4 Tertiary goal * Metabolic Syndrome TG < 1.7 mmol/l HDL 1.0mmol/l(men)/ 1.3mmol/l (women) CCS Recommendations for the Dx & Tx Dyslipidemia-2006 (NCEP ATP III Revision 2004)	<table border="1" data-bbox="459 564 1427 787"> <thead> <tr> <th data-bbox="459 564 716 625">Lipid Profile</th> <th data-bbox="716 564 1040 625">1st Line Therapy</th> <th data-bbox="1040 564 1427 625">2nd Line Therapy</th> </tr> </thead> <tbody> <tr> <td data-bbox="459 625 716 663">LDL ↑</td> <td data-bbox="716 625 1040 663">Statin</td> <td data-bbox="1040 625 1427 663">Resin</td> </tr> <tr> <td data-bbox="459 663 716 701">LDL ↑↑ & TG</td> <td data-bbox="716 663 1040 701">Statin</td> <td data-bbox="1040 663 1427 701">Niacin or Fibrate</td> </tr> <tr> <td data-bbox="459 701 716 739">LDL ↑ & TG ↑↑</td> <td data-bbox="716 701 1040 739">Fibrate or Niacin/Niaspan®</td> <td data-bbox="1040 701 1427 739">Combination Therapy</td> </tr> <tr> <td data-bbox="459 739 716 787">TG ↑ & HDL ↓</td> <td data-bbox="716 739 1040 787">Fibrate or Niacin/Niaspan®</td> <td data-bbox="1040 739 1427 787">Combination Therapy</td> </tr> </tbody> </table> <p data-bbox="459 787 1427 1087"> * Primary goal: For patients CHD Risk equivalent: any of CAD, TIA, CVA, AAA, PVD/bruits, DM with one additional categorical risk factor or for patients with very high 10-year risk for hard CV events (20%). • Target initial Rx medication dose required to achieve target LDL <2.0 (1.8) mmol/L. Min. 50% LDL ↓ • For 10 yr CV risk for hard endpoints 10-20%, LDL Rx threshold is 3.5 mmol/L. Minimum 40% LDL ↓ • For 10 yr CV risk for hard endpoints < 10%, LDL Rx threshold is 5.0 mmol/L. Minimum 40% LDL ↓ • Initiate lipid lowering early in high-risk patients (in conjunction with dietary modification). For specific medications and dosing strategy see Lipid Optimization Tool </p>	Lipid Profile	1 st Line Therapy	2 nd Line Therapy	LDL ↑	Statin	Resin	LDL ↑↑ & TG	Statin	Niacin or Fibrate	LDL ↑ & TG ↑↑	Fibrate or Niacin/Niaspan®	Combination Therapy	TG ↑ & HDL ↓	Fibrate or Niacin/Niaspan®	Combination Therapy
Lipid Profile	1 st Line Therapy	2 nd Line Therapy															
LDL ↑	Statin	Resin															
LDL ↑↑ & TG	Statin	Niacin or Fibrate															
LDL ↑ & TG ↑↑	Fibrate or Niacin/Niaspan®	Combination Therapy															
TG ↑ & HDL ↓	Fibrate or Niacin/Niaspan®	Combination Therapy															
	Hypertension Goal < 140/90 (Office BP) < 135/80 (Home BP) < 130/80 (DM) 2006 CHS www.hypertension.ca Earlier Dx is key BP control – focus on adherence: long acting Rx/fixed dose combinations	<ul data-bbox="459 1087 1427 1640" style="list-style-type: none"> • Assess BP at all visits. Assess global CV risk. Lifestyle modifications are cornerstone of anti-hypertensive and anti-atherosclerotic therapy. • Initiate Rx immediately if hypertensive urgency. Dx HTN on second visit if : target organ damage, DM, chronic kidney disease (CKD) or BP > 180/110.Dx HTN on 3rd visit if BP ≥ 160 or ≥ 100 • Validate hypertension with: 1) Office BP(<140/90), ambulatory BP(< 135/85 daytime average/ or 130/80-24 hr average) or home/self BP(<135/85). Target < 140/90 office BP or < 130/80 DM or CKD. • Initial Rx for systolic/diastolic HTN in absence of compelling indication: Low dose thiazide; β-blocker if age < 60 yr; ACE-I § in non-black pts; long-acting CCB and ARB. ISH: LDD/ DHP-CCB/ARB • Consider Rx ASA (once BP controlled) and statin in HTN patients if ≥ 3 CV risks. • CHF&HTN-Rx β-blocker †; ACE-I (ARB if ACE-I intolerant) & aldosterone antagonist (Class III/IV HF) • CKD or Type 2 DM § with micro-albuminuria, proteinuria or nephropathy ACE-I/ARB are 1st line Rx 															
	Diabetes 2003 CDA Guidelines Released Dec. 2003	<ul data-bbox="459 1640 1427 1932" style="list-style-type: none"> • Dx DM: FBG ≥ 7.0 mmol/L or 2 hr PC Glucose ≥ 11.1 mmol/L. (Normal: A1C ≤ 6; FBG 4-6 mmol/L; 2 hr PC Glucose 5-8 mmol/L.) Dx Impaired Fasting Glucose: 6.1-6.9 mmol/L. Dx Impaired Glucose Tolerance: 2 hr PC Glucose 7.8-11 mmol/L. • Target euglycemia ASAP. Initiate diet to achieve weight loss (5-10%), diabetes education & exercise program. Target A1C ≤ 7; FBG 4-7 mmol/L; 2 hr PC Glucose 5-10 mmol/L. Rx oral hypoglycemic for FBG ≥ 7.0 mmol/L & A1C 7-9.Consider initial combination Rx for A1C ≥ 9. • Aggressive BP control. Target <130/80 Rx ACE-i, ARB, cardio-selective β-blocker, thiazide diuretic, long acting CCB. BP target 125/75 for diabetic nephropathy removed. 															

CARDIOVASCULAR RISK REDUCTION CHECKLIST

Rx ✓	Intervention	Recommendations
	Physical activity: Minimum goal 30 minutes 3 to 5 times/week <i>HR guided</i>	<ul style="list-style-type: none"> Assess risk, preferably with exercise test, to guide prescription. Encourage minimum of 30-40 minutes of moderate intensity activity 3 to 5 times weekly (walking, jogging, cycling or other aerobic activity) supplemented by an increase in daily lifestyle activities (e.g., walking breaks at work, using stairs, gardening, household work) Max benefits 5 to 6 hours per week. Medically supervised programs for moderate to high-risk patients.
	Obesity/weight management:	Start intensive diet and appropriate physical activity intervention, as outlined above, in patients >120% of ideal weight for height. Particularly emphasise need for weight loss in patients with hypertension, elevated triglycerides or elevated glucose levels. Ideal body weight BMI < 25
	Antiplatelet agents/ anticoagulants:	Start aspirin 81-325 mg per day if not contraindicated. Consider clopidogrel 75mg OD post MI, post CABG, CVA, PVD in ASA intolerant or allergic patients (CAPRIE Trial). Consider clopidogrel 75mg OD + ASA for ACS: unstable angina/non-ST elevation MI (<i>CURE Trial</i> : duration of therapy 9-12 months). No chronic benefit of ASA+ clopidogrel (<i>CHARISMA</i>). Consider warfarin for post MI patients unable to take aspirin (maintain INR 2-3).
	ACE INHIBITORS/ ARBs Post-MI/LV Dysfunction:	Start early post-MI in stable high risk patients (anterior MI, previous MI, Killip class II (S3 gallop, rales, radiographic CHF). Continue indefinitely for all with LV dysfunction (EF<40%) or symptoms of CHF. Use as needed to manage HPT or symptoms in all other patients. Valsartan in ACE intolerant patients <i>VALIANT</i>
	ACE inhibitors § Vascular Disease / Diabetes	Rx ACE inhibitors in all patients >55 yrs with evidence of vascular disease or DM and one other risk factor: <i>HOPE Trial</i> - Ramipril 2.5 → 10 mg OD or all CAD patients >18 yrs <i>EUROPA Trial</i> -Perindopril 4 → 8 mg OD. If LVF preserved, patient non diabetic and other risk factors optimized may not need ACE inhibitor (<i>PEACE</i>).
	Beta-blockers: Post-MI	Start acutely or within a few days of event in all post-MI patients (unless contra-indication). Continue indefinitely if residual ischemia, heart failure LV dysfunction or severe co-morbidity. Continue indefinitely in low risk patients (IIa). Rx as needed to manage angina, arrhythmia or HPT.
	Beta-blockers: CHF †	Rx Add Beta-blocker to ACE-inhibitor/diuretic/+/- digoxin in stable Class II-IV CHF/LVEF ≤ 40% Bisoprolol 1.25 → 10 mg OD, carvedilol 3.125 mg BID → 25 mg BID (50 mg BID if weight > 85 kg) or metoprolol 12.5 mg → 75-100 mg BID
	Omega-3 fatty acids HOMOCYST(E)INE	Rx: Omega-3 fatty acids 1-3 gm/day. No identifiable benefit in lowering elevated homocysteine with vitamin supplements combining folic acid, B6 and B12 in patients with CVD, DM or post MI. <i>HOPE 2/NORVIT</i> .
	Estrogens	HRT not recommended for 1° or 2° prevention. Stop HRT in ACS, MI, PTCA, CABG, CHF, other surgery.

Other Information and Diet Sheets Available:

- Dyslipidemia Package
- Diet for Type 2 Diabetes
- Diet for Hypertension
- Diet for Congestive Heart Failure
- Potassium Replacement Diet
- Weight Management

Please visit www.ottawacvcentre.com for more information.

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www.cvtoolbox.com

Discharge Summary May 2007
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CV RISK FLOWSHEET

Rx (✓)	Risk Intervention	Date ✓ Achieved	Date ✓ Achieved	Date ✓ Achieved	Date ✓ Achieved	Date ✓ Achieved	Date ✓ Achieved
	Ideal body weight: BMI < 27 kg/m ² (ideally < 25 kg/ m ²)						
	Girth: <i>Targets</i> M < 94 cm; F < 80cm; lower in SE Asian males W/H: M < 0.95; F < 0.9						
	Physical activity: Minimum goal > 200 min./week						
	Smoking Goal: Complete cessation						
	Lipid Management:						
	<i>Primary goal:</i> LDL < 2.0 (1.8) mmol/L						
	<i>Secondary goal:</i> TC/HDL < 4						
	Metabolic Syndrome HDL ≥ 1.0 mmol/L M HDL ≥ 1.3 mmol/L F						
	TG < 1.7 mmol/L						
	Apo B: <i>Hi risk</i> < 0.85g/L; <i>Mod risk</i> < 1.05 g/L; <i>Low risk</i> < 1.2 g/L						
	Blood pressure: <i>Targets</i> ≤ 135/85 mm Hg - HBPM/ABPM ≤ 130/80 mm Hg for DM/CKD						
	Diabetes: <i>Targets</i> FBS 4-6 mmol/L 2hr PC Glucose 5-10 mmol/L HbA1C ≤ 7%						
	MAU: <i>Targets</i> Spot urine < 20/mg/L ACR < 2.0 Men ACR < 2.8 Women						
	Antiplatelet agents: ASA or Plavix						
	Anticoagulants: Target INR _____						
	ACE inhibitor/ARBs: Post-MI						
	ACE inhibitors: Vascular protection/CAD						
	Beta-blockers: Post-MI						
	Beta-blockers CHF/LV Dysfunction: LVEF < 40%						
	Rx: Omega-3 fatty acids (salmon oil or flax) 1-3 gm/day						
	LP(a) < 30 mg/dL						
	hs-CRP High risk > 3.0 mg/L; Mod risk 1.0-3.0 mg/L; Low risk < 1.0 mg/L						
	HRT: Off						