Optimizing heart failure care
from hospital discharge to patient follow-up

Multi-center patient support program

N IC4 -16257 -025 – RUS
Check list for follow up HF pts with systolic dysfunction

City ______________________________

Name of the patient care institution_________________________

Doctor’s name_____________________________

Doctor’s phone number __ (____) _____________

Patient’s name________

Patient’s gender________

Patient’s age________

Check list for follow up HF pts with systolic dysfunction

Parametrs	Hospital	Outpatient stage				
	(before discharge)	V 1 7 - 14 D after discharge	V2 1 M (+14D)	V 3 3 M(+14D)	V 4 6 M (+14D)	V 5 12 M (+14D)
	Date__________ _	Date __________	Date __________	Date __________	Date __________	Date __________
Weight, kg **Height, sm** **HR (by ECG), bpm** **SBP/DBP mmHg** ***Sign of congestion:*** crepitation/ crackles ↑Hepar peripheral edema ***NYHA*** **class** **LVEF, %** ***Rhythm*** **Creatinine, mkmol/l** **K+, mmol/l** **EchoCG**** **QoL (points)*****	________ ________ ________ yes no yes no yes no II III IV ________ Sinus Other, please specify ________ ________ (date)________ (date)________	____________ _ ____________ _ ____________ _ ________ yes no yes no yes no II III IV ____________ _ Sinus Other, please specify ____________ _ ____________ _ (date)_______ (date)_______	___________ __ ___________ __ yes no yes no yes no II III IV ___________ __ Sinus Other, please specify ___________ __ ___________ __ (date)____ (date)___	___________ __ ___________ __ yes no yes no yes no II III IV ___________ __ Sinus Other, please specify ___________ __ ___________ __ (date)___ (date)___	___________ __ ___________ __ yes no yes no yes no II III IV ___________ __ Sinus Other, please specify ___________ __ ___________ __ (date)____ (date)____	___________ __ ___________ __ yes no yes no yes no II III IV ___________ __ Sinus Other, please specify ___________ __ ___________ __ (date)_____ _ (date)___
Compliance by the patient self-testing conditions? (outline) Weight check (2 times/week) Diet adherence Cheking HR and BP Pts education	yes no yes no yes no 1 2 3 4	yes no yes no yes no 1 2 3 4	yes no yes no yes no 1 2 3 4	yes no yes no yes no 1 2 3 4	yes no yes no yes no 1 2 3 4	yes no yes no yes no 1 2 3 4
Recurrent hospitalization or withdrawal(W)		Hospit. W cause__________ _______________ date _____________	Hospit. W cause_______ _____________ date _____________ _	Hospit. W cause_______ _____________ date _____________ _	Hospit. W cause_______ _____________ date _____________ _	Hospit. W cause________ _____________ date _____________

Other clinical events since the last visit		Diagnosis ______ Date ______	Diagnosis ______ Date ______	Diagnosis ______ Date ______	Diagnosis ______ Date ______	Diagnosis ______ Date ______

*Guidelines based prognosis-modifying pharmacotherapies**

ACEi/sartans	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated
BB	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated
MRA	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated
Ivabradine	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated	Y N contra-indicated
Pts' adherence	high / moderate / low	high / moderate / low	high / moderate / low	high / moderate / low	high / moderate / low	high / moderate / low

*- ACEi – if LVEF ≤40% *(cough or intolerance – sartans)*
BB- if LVEF ≤40%
MRA – if LVEF ≤35%, К+*<5.0 mmol/l, creatinine<200mkmol/l*
Ivabradine – a) if sinus rhythm and Pts treated with BB but HR>70 bpm; б) if BB contra-indicated
** EchoCG – at least 2 times per observation (timeline – Drs'decision)

***QoL assessment (points) **-** by Scale of the Russian Society of Heart Failure

Please fill in the Adverse Event Form **Pharmacovigilance form** (see attachment Annex I) **and fax it (495) 937-47-66** to Servier if the followings occurred:
- serious adverse drug reactions related to Servier drug intake
- non-serious adverse drug reactions related to Servier drug intake
- adverse events in relation to Servier drug withdrawal
Reports of special situations (see the Protokol)
In case of serious adverse reaction or serious adverse event in relation to Servier drug withdrawal, the Adverse Event Form should be filled in and sent by fax within 24 hours. In other cases – within 2 days.

ANNEX 1

PHARMACOVIGILANCE FORM

The report about an adverse reaction/adverse event related to Servier drug withdrawal in Optimize heart failure care study

Please send this form immediately by fax 8(495) 937-47-66 (for N.Korneeva)

□ Initial report □ Follow up report

Date of birth: |_|_|.|_|_|.|_|_|_|_| year

Gender: □ M □ F

Height: |_|_|_|cm

Weight:|_|_|_|kg

Patient's initials |_|_|_|

Description of the adverse reaction:

Onset date |_|_|.|_|_|.|_|_|_| _| year

Date of recovery |_|_|.|_|_|.|_|_|_| _| year

General disease(s)/concomitant disease(s) (report the date of the diagnosis establishment)

Course of the adverse event (report the appropriate information, for example, the results of the analyses, of the histological examination and of other examinations, the data from the discharge letter e t.c.)

Therapy prescribed for treatment of this adverse reaction

Seriousness criteria:

□No □Yes (specify, choose from the list below)
□ fatal outcome
□ life-threatening
□ hospitalization or prolongation of hospitalization
□ permanent disability
□ birth defect
□ medically-important event

Relationship with the Servier drug

□No □Yes

If yes, please, specify the drug

□ recovered____________________
the date of recovery
□ the patient didn't recover
□ outcome is unknown
□ permanent functional/structural disorder
□ fatal outcome

Outcome:

The list of taken drugs	Daily dose/route	Dates of intake: from______to_____	Indication
1			
2			
3			
4			

Physician's surname, name, patronymic:
Profession:
Work address:
Phone number: 8(____)_______________

Date:

Signature: