Heart Failure (HF)

Self management goal plan

Patient name _____

Date of birth _____

Daytime phone # _____

Address _____

City/State/Zip _____

Today's date _____

Follow up time frame:

_____

_____

_____

_____

Goal setting

1. Choose an activity goal below:

❑ I will know my (check all that apply):

❑ Early symptoms of worsening heart failure (rapid weight gain, increasing shortness of breath, swelling)

_____

❑ Green, yellow, and red zones on my HF action plan.

❑ I will follow the action plan and take my medicines prescribed by my doctor.

❑ I will weigh myself daily and jot it down.
(If weight gain_____)

❑ I will quit smoking or reduce smoking to _____ cigarettes per day.

❑ I will get physically active by _____, _____ minutes per day, _____ times per week.

❑ I will discontinue alcohol use or reduce alcohol to _____ drinks per week.

❑ I will adhere to a low-sodium diet by:

- ❑ Not adding salt to my foods when cooking
- ❑ Not adding salt to food I eat
- ❑ Using a salt substitute
- ❑ Reading food labels (check sodium amount).

❑ I will follow fluid guidelines advised by my doctor:

_____

2. Choose your confidence level:

I think I can succeed at this goal:

Not sure				*Somewhat sure*					*Very sure*
0				5					10

3. Fill in the following for your chosen goal:

What: _____

_____

_____

_____

When: _____

_____

_____

_____

How much: _____

_____

_____

How often: _____

_____

_____

Barriers to meeting goals: _____

_____

_____

Clinician signature

THE PHYSICIAN ALLIANCE