Cardiac Care Plan

HeartMate 3™ VAD

If desired, add Hospital Logo here
(align logo to right margin)

Delete Text Box

Academic Year: _____ - _____

This plan must be completed by the child's personal cardiac health care provider/physician and parents/guardian and immediately updated by these persons with any new information in the future.

All entries must be completed or the plan will be deemed incomplete and unsatisfactory.
Please attach additional pages as needed.

Patient Information

Patient Name:			
	First	*Middle*	*Last*
DOB: *MM / DD / YYYY*		**Grade:**	
Diagnosis:		**Date of Diagnosis:** *MM / DD / YYYY*	
Device Type/Name/Model:			
Allergies:			
Surgical History:			
Other Medical History:			

Parent/Caregiver Contact Information

Parent/Caregiver 1:	
Home Address:	

Phone: - - ☐ *Home* ☐ *Mobile* ☐ *Other* _____

Additional Emergency Contacts		
Name	Relation	Phone

Hospital & Provider Contact Information

Cardiologist:	
Hospital Name:	
Hospital Address:	
Instructions to contact care team: *ex. "XXX-XXX-XXXX request VAD coordinator on call"*	
Other Contact Notes:	

MONITORING

Frequency of Monitoring:

Can child perform own monitoring and care? Please specify.

What signs does the child demonstrate when child is symptomatic and/or in need of intervention?

What signs does the device demonstrate when in need of intervention?

☐ ** Algorithm Attached*

When should parent/caregiver or emergency contact be notified?

NUTRITION

Foods or beverages to avoid, if any:

Instructions for when food or beverage is provided to the child (e.g., as part of a party or food sampling event):

ACTIVITY

List, identify, and explain restrictions to exercise, sports, or any other activities:

HM3 - Patient is unable to swim, should not participate in contact sports.

EQUIPMENT

Supplies to be kept at the school and provided by parent/guardian are as follows:

Equipment/Supplies *ex. Driveline Dressing*	Instructions for Use *ex. If dressing nonocclusive reinforce with Tegaderm.*

INJURIES & EMERGENCIES

IF PATIENT BECOMES UNRESPONSIVE, CALL 911 AND FOLLOW BLS PROTOCOL.
Please note, the patient may not have a palpable pulse due to device continous flow.

	ACTIONS TO TAKE	WHO TO CALL
BLEEDING		
DRIVELINE TRAUMA		

OTHER

Any other special accommodations or modifications required as a result of the cardiac condition:

MEDICATIONS

Please include medicines and directions for use in the chart below.

MEDICINE	FREQUENCY	MEDS GIVEN AT SCHOOL?	If YES, dose due at:	SPECIAL MONITORING/ CONSIDERATIONS
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		

Care Team Approval

This Cardiac Care Plan has been completed and approved by:

Attending	
Name:	
Contact Info:	
Signature:	
Date:	

VAD Coordinator	
Name:	
Contact Info:	
Signature:	
Date:	

Parent/Caregiver Approval

I attest that the aforementioned information is true and accurate. I give permission to _____ to perform and carry out care tasks as outlined in the Cardiac Care Plan. I also consent to the release of the information contained in this Cardiac Care Plan to all staff members and other adults who have custodial care of my child, such as those persons on the emergency list and who may need to know this information to maintain my child's health and safety. A written revocation or amendment to this document must be delivered to the school by the child's Parent/Guardian in order to effectuate a revocation of the same. The school reserves the right to request additional documentation after review of the within document based on its reasonable discretion, and/or the requirements of State law and the regulations and policies.

Patient's Parent/Caregiver 1	
Name:	
Relation to Patient:	
Contact Info:	
Signature:	
Date:	

Patient's Parent/Caregiver 2	
Name:	
Relation to Patient:	
Contact Info:	
Signature:	
Date:	