Cardiac Shunt-dependent patient
Discharge Instructions

Sibley Heart Center 404-256-2593/800-542-2233 (toll free)

Diagnosis: _____

Previous Surgical Procedures: _____

Baseline Oxygen Saturations: _____ % ❒ RA ❒ O_2 _____ **L/min**

Medication	Concentration	Dose	Frequency	Rx given
❒**Aspirin**				❒
❒**Lasix (furosemide)**	**10mg/ml**			❒
❒**Zantac (ranitidine)**	**15mg/ml**			❒
				❒
				❒
				❒
				❒
❒No change from previous visit ❒ No Medication				

Diet: Give _____ ml of _____ Kcal/oz _____ formula every _ hours

❒ by mouth by ❒ NG Tube / G Tube Target minimum intake for 24 hours: _____

Monitor Weight:
- ❒ Home Health nurse to check and record _____ times a week
- ❒ Primary pediatrician to check and record _____ times a week
- ❒ Family to check and record daily

NOTIFY CARDIOLOGIST IF WEIGHT GAIN IS LESS THAN 5 *ounces per week*
NOTIFY CARDIOLOGIST IF THERE IS ANY WEIGHT LOSS

Monitor Oxygen Saturations:
- ❒ Home Health nurse to check and record _____ times a week
- ❒ Primary pediatrician to check and record _____ times a week
- ❒ Family to check and record daily

NOTIFY CARDIOLOGIST IF OXYGEN SATURATIONS ARE LESS THAN _____%

Additional Instructions: _____

_____

_____

Red Flag Instructions: Call your cardiologist office if these symptoms occur

- Temperature over 100.5F
- Increase in difficulty breathing / turning blue
- Problems with feeding
- Persistent cough
- Vomiting / Diarrhea > two episodes in 24 hours
- Saturations less than _____%
- Weight gain of less than 5 ounces per week
- Any weight loss

Health Maintenance:
- ❒ Pediatrician should administer routine childhood immunizations
- ❒ RSV prophylaxis should be arranged by pediatrician's office
- ❒ Influenza prophylaxis should be considered for close contacts, per CDC protocol

Patient testing: ❒ Schedule for Cath**:** _____ ❒ Schedule for Surgery

Next Appointments (Physician and location):

Cardiologist: _____ on _____ @ _____

Pediatrician: _____ on _____ @ _____

Parent / Guardian Signature: _____

Nurse Signature: _____ **Patient Name:** _____

Physician Signature: _____ **Date of Visit:** _____

Physician Name printed: _____ **Medic #:** _____