University of Michigan
Cardiovascular Center

Patient Agreement: Heart Failure Telemanagement Program

This program aims to support, teach, and guide me through the complex treatment of heart failure.

I agree to do all of the following:

- ☐ Keep all my appointments.
- ☐ Get blood tests (needed for decisions about my care).
- ☐ Be available by phone.
- ☐ Notify the program as soon as possible (within 24-48 business hours):
  - If I am left a message to return a call.
  - If I am discharged from a hospital or ER **734-647-7321** or **1-888-287-1082** (UM or other).
  - If my address or phone number change.
- ☐ Follow instructions about complying with my treatment plan –
  - taking medication regularly,
  - eating a proper diet (such as sodium and fluid restricted diet), and
  - telling the clinic about all drugs I am taking (including over-the-counter drugs and supplements)
  - make recommended life style changes

I understand all of the following:

- ☐ Sticking to the treatment plan (all of it) will make the difference in getting the optimal benefits of care.
- ☐ The Heart Failure Self Care Goals.
- ☐ Failing to do any of the above can result in serious health risks and/or hospitalizations.

I may be contacted at the following numbers:

Home: (__ __ __) __ __ __ - __ __ __ __ Other: (__ __ __) __ __ __ - __ __ __ __

My correct address: _____ _____
Street number & name Apt. # (if applicable)

_____ _____ _____
City State Zip Code

_____ _____ _____ _____
PATIENT Signature **Date** **WITNESS Signature** **Date**

Disclaimer: This document is for informational purposes only and is not intended to take the place of the care and attention of your personal physician or other professional medical services. Talk with your doctor if you have Questions about individual health concerns or specific treatment options.

Control #429
Last Revised April 2010