Pharmacy:_____
Date:_____
Student :_____

The One Minute Clinic (TOM-C)
Community Intervention Program for Heart Failure

Since your last refill or visit to your doctor

Triggers to Contact Physician/Nurse (one YES checked)			*No*
Have you had a change in weight? ____lbs	☐	YES > 5lbs weight gain	☐
Are you carrying more water? *Edema: Shoes fit – same or newly tight - or* *Ankle edema - > 1+ - or* *Patient observation - ankle or any edema or sense of increase water:*	☐	YES - MORE edema ☐ Tight shoes, and/or > 1+ edema ☐ Ankle edema ☐ Patient observation	☐
Do you have shortness of breath: (If yes, more or same or less)	☐	YES - MORE shortness of breath	☐
Do you wake up short of breath at night: (if yes – more or same or less)	☐	YES - MORE shortness of breath at night	☐
How many pillows do you sleep on ____? (more or same or less)	☐	YES - MORE pillows at night	☐
Have you been at all dizzy or have felt like you will faint: (If yes, upon standing?)	☐	YES - Symptoms of dizziness/fainting ☐ Dizzy or faint upon standing	☐
Heart Rate _____ (optional) Blood Pressure _____ (optional)	☐ ☐	Heart rate < 50 if symptoms of tiredness or dizziness or fainting Heart rate < 40 regardless of symptoms	☐

Triggers to Counsel Patient to Contact their Physician/Nurse Soon (one YES checked)			*No*
Have you felt more tired? *Examples* *1. Housework (more or same or less)* *2. Grocery shopping (more or same or less)* *3. Exercise/walking (more or same or less)* 4. *Other*	☐	YES - Increased Tiredness ☐ Less housework ☐ Less Grocery shopping ☐ Less exercise/walking ☐ Other	☐
Are you having any problems sleeping?	☐	YES - Recent Sleep Problems	☐
Has your appetite changed recently?	☐	YES - Recent Loss of Appetite	☐

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Intervention Summary:				
Optional Question: Last time you took your water pill (drug name) do you think it is working the <u>same</u> as usual or <u>not as well</u>? (This may be key information to relay to physician/nurse)				
What intervention step was followed?	☐ Physician/Nurse Contacted by Pharmacist	☐ Patient to Follow Up	☐ Other:	
If Physician/Nurse was contacted, please select all that apply:	☐ Therapeutic Intervention	☐ Office Visit Scheduled	☐ Advise ER Visit	☐ No Intervention
If a Therapeutic Intervention was implemented, please select all that apply:	☐ Changed Diuretic Dose	☐ Changed Diuretic Administration Frequency	☐ Added Thiazide Diuretic	☐ Changed to a Different Loop Diuretic
	☐ Hold Diuretics	☐ Changed BB or ACE-I Dose	☐ Added additional therapies _____	☐ Other (please specify) _____

Pharmacist Intervention Impressions:				
How much time did your intervention take?	☐ 1-5 Minutes	☐ 5-10 Minutes	☐ >10 Minutes	
Is this of value to you professionally?	☐ Not at all Valuable	☐ Somewhat Valuable	☐ Valuable	☐ Highly Valuable
Do you think this is of value to the patient?	☐ Not at all Valuable	☐ Somewhat Valuable	☐ Valuable	☐ Highly Valuable
Optional – Medication Profile (Including Dose)				

For information, questions or permission requests please contact:
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