MARVIX AI

HEART FAILURE & ADVANCED HEART FAILURE SOAP NOTE TEMPLATE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

REFERRAL SOURCE

VISIT TYPE: HEART FAILURE / ADVANCED HEART FAILURE CONSULTATION / FOLLOW-UP

CARE SETTING: OUTPATIENT / INPATIENT / TELEHEALTH / HEART FAILURE CLINIC / TRANSPLANT-VAD CLINIC

PRIMARY CARE PROVIDER, IF APPLICABLE

PRIMARY CARDIOLOGIST, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY HEART FAILURE CONCERN

Primary heart failure-related reason for the visit in the patient's own words when possible — shortness of breath, edema, weight gain, fatigue, reduced exercise tolerance, medication optimization, hospital follow-up, advanced therapy evaluation, transplant evaluation, LVAD evaluation, or worsening heart failure symptoms...

S SUBJECTIVE

3 PATIENT-REPORTED SYMPTOMS, FUNCTIONAL STATUS & INTERVAL COURSE

3a INDICATION & HEART FAILURE HISTORY

Reason for Heart Failure Evaluation (initial evaluation, routine follow-up, post-hospital follow-up, medication optimization, volume assessment, cardiomyopathy evaluation, advanced heart failure evaluation, transplant evaluation, LVAD evaluation, pulmonary hypertension assessment, palliative heart failure discussion):

Heart Failure History (diagnosis date, type of heart failure, known EF, etiology, prior decompensations, hospitalizations, cardiomyopathy history, ischemic / nonischemic cause, prior myocarditis, valvular disease, congenital disease, chemotherapy / radiation exposure, family history of cardiomyopathy):

3b CONGESTION, FUNCTION & VOLUME STATUS

Dyspnea and Congestion Symptoms (exertional dyspnea, dyspnea at rest, orthopnea, PND, bendopnea, abdominal bloating, early satiety, edema, weight gain, cough, wheezing, worsening oxygen requirement):

Functional Capacity (activity tolerance, walking distance, stair tolerance, ability to perform ADLs, NYHA class, exercise limitation, cardiac rehab participation, change from baseline):

Weight and Volume Status History (home weights, recent weight change, dry weight, diuretic response, fluid intake, sodium intake, edema trend, urine output, adherence to weight monitoring):

Blood Pressure and Heart Rate History (home BP readings, heart rate trends, hypotension, dizziness, orthostasis, syncope, hypertension, medication tolerance):

3c ISCHEMIC, ARRHYTHMIC & DEVICE SYMPTOMS

Chest Pain / Ischemic Symptoms (chest pain, pressure, exertional symptoms, angina equivalent, nitroglycerin use, associated diaphoresis / nausea, prior CAD, MI, PCI, CABG, ischemia evaluation):

Arrhythmia / Device Symptoms (palpitations, atrial fibrillation, ventricular arrhythmias, ICD shocks, device alerts, syncope, presyncope, pacemaker / ICD / CRT history, remote monitoring status):

3d MEDICATIONS, ADVANCED THERAPY & INTERVAL EVENTS

Medication History and GDMT Tolerance (current heart failure medications, adherence, missed doses, side effects, affordability / access issues, recent dose changes, renal / electrolyte limitations, hypotension, hyperkalemia, bradycardia, diuretic tolerance):

Advanced Heart Failure Symptoms (recurrent hospitalizations, escalating diuretic needs, intolerance to GDMT, worsening renal function, hypotension, cachexia, low-output symptoms, frequent ICD shocks, inotrope use, progressive functional

decline):

Transplant / LVAD Considerations, if applicable (transplant referral status, LVAD evaluation status, inotrope dependence, psychosocial support, caregiver availability, substance use status, adherence, frailty, pulmonary hypertension, renal / hepatic dysfunction, patient preferences):

Relevant Medical History (CAD, hypertension, diabetes, CKD, COPD, sleep apnea, obesity, valvular disease, pulmonary hypertension, stroke / TIA, peripheral artery disease, thyroid disease, anemia, malignancy history, prior thromboembolism):

Lifestyle / Self-Management (sodium restriction, fluid restriction, daily weight monitoring, exercise, cardiac rehab, tobacco use, alcohol use, stimulant use, sleep apnea treatment, medication organization, understanding of the heart failure action plan):

Recent Testing / Hospitalizations (ED visits, admissions, IV diuresis, echocardiogram, cardiac MRI, catheterization, right heart catheterization, stress testing, labs, device interrogation, medication changes, procedures):

Pertinent Negatives (severe dyspnea at rest, chest pain, syncope, rapid weight gain, worsening edema, ICD shock, hemoptysis, acute neurologic deficit, severe hypotension, signs of cardiogenic shock):

ROS HEART FAILURE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Dyspnea, orthopnea, PND, bendopnea, cough, or reduced exercise tolerance

Edema, abdominal bloating, early satiety, weight gain, or decreased urine output

Chest pain, chest pressure, palpitations, dizziness, presyncope, or syncope

Fatigue, weakness, poor appetite, cachexia, or sleep disturbance

ICD shocks, device alerts, or arrhythmia symptoms

Diuretic side effects, hypotension, lightheadedness, or medication intolerance

Bleeding, bruising, anticoagulation issues, or thromboembolic symptoms

Tobacco, alcohol, stimulant, diet, fluid, or medication adherence concerns

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

WEIGHT

BMI

DRY WEIGHT, IF KNOWN

ORTHOSTATIC VITALS, IF OBTAINED

5a GENERAL, CARDIOVASCULAR & PULMONARY

General Appearance (distress level, work of breathing, body habitus, frailty, nutritional appearance, ability to speak in full sentences, overall clinical condition):

Cardiovascular (rate, rhythm, murmurs, rubs, gallops, JVP, hepatojugular reflux, peripheral pulses, capillary refill, edema, signs of volume overload or low perfusion):

Pulmonary (breath sounds, crackles, wheezing, diminished breath sounds, work of breathing, oxygen requirement, pleural effusion or pulmonary edema findings):

5b ABDOMEN, EXTREMITIES, SKIN & NEUROLOGIC

Abdomen (distension, tenderness, hepatomegaly, ascites, abdominal bloating, findings related to venous congestion):

Extremities (edema severity, laterality, temperature, pulses, cyanosis, wounds, perfusion, signs of peripheral vascular disease):

Skin (pallor, diaphoresis, cyanosis, wounds, surgical scars, device pocket findings, bruising, signs of poor perfusion):

Neurologic (mentation, focal deficits, weakness, gait concerns, findings relevant to low perfusion, stroke risk, or anticoagulation):

DA DEVICE / ADVANCED THERAPY EXAMINATION, IF APPLICABLE

6 CARDIAC DEVICE & MECHANICAL CIRCULATORY SUPPORT

PACEMAKER, ICD, OR CRT DEVICE SITE FINDINGS

LVAD TYPE AND DRIVELINE SITE

LVAD HUM AND MAP BY DOPPLER, IF APPLICABLE

TRANSPLANT SURGICAL SCAR OR POST-OPERATIVE FINDINGS

CENTRAL LINE, PICC, OR INOTROPE INFUSION SITE FINDINGS

Device pocket tenderness, erythema, swelling, drainage, erosion, or hematoma:

LVAD driveline dressing status, drainage, erythema, tenderness, or alarms:

LVAD device parameters when available (speed, flow, power, pulsatility index):

L HEART FAILURE TESTING / DIAGNOSTIC RESULTS

7 RESULTS REVIEWED OR ORDERED

EKG (rhythm, rate, conduction abnormalities, QRS duration, QTc, ischemic changes, arrhythmias, comparison to prior EKG):

Echocardiogram (EF, LV / RV size and function, wall motion, diastolic function, valve disease, pulmonary pressures, IVC findings, pericardial effusion, comparison to prior study):

Cardiac MRI / CT (cardiomyopathy characterization, scar / fibrosis, infiltrative disease, myocarditis, viability, congenital anatomy, structural findings):

Cardiac Catheterization (coronary anatomy, prior PCI / CABG findings, LVEDP, hemodynamics, cardiac output / index, filling pressures, pulmonary pressures, vascular resistance):

Right Heart Catheterization (RA pressure, PA pressure, PCWP, cardiac output / index, SVR, PVR, mixed venous saturation, vasodilator testing):

Stress Testing / Functional Testing (stress test findings, CPET results, 6-minute walk distance, peak VO_2, VE/VCO_2 slope, cardiac rehab data):

Device Interrogation (ICD / CRT function, pacing percentage, biventricular pacing percentage, arrhythmia burden, shocks / ATP, battery status, programming changes):

Laboratory Studies (BNP / NT-proBNP, BMP, magnesium, renal function, electrolytes, liver function, CBC, iron studies, TSH, A1c, lipid panel, lactate, medication-monitoring labs):

Imaging (chest X-ray, CT chest, vascular imaging, transplant / LVAD workup imaging, other relevant studies):

Prior Records Reviewed (hospital records, cardiology notes, heart failure clinic notes, cath reports, imaging reports, device reports, medication history, transplant / LVAD records, lab trends):

A ASSESSMENT

8 HEART FAILURE CLINICAL INTERPRETATION

Primary heart failure diagnosis or working diagnosis. Heart failure type, EF category, etiology, and cardiomyopathy classification. NYHA class and functional limitation. ACC/AHA stage. Current volume status and perfusion status. Recent decompensation risk or post-hospital recovery status. GDMT status, tolerance, adherence, and optimization opportunities. Diuretic response and dry weight assessment. Renal function, electrolytes, and medication-limiting factors. Arrhythmia or device-related issues. Valvular, ischemic, pulmonary hypertension, or RV failure contribution. Advanced heart failure markers including recurrent hospitalizations, inotrope need, hypotension, worsening renal function, cachexia, or GDMT intolerance. Transplant, LVAD, palliative care, or goals-of-care considerations. Need for medication changes, diagnostic testing, device evaluation, advanced therapy referral, hospitalization, or close monitoring...

P PLAN

9 HEART FAILURE MANAGEMENT BY PROBLEM

GDMT plan (ARNI / ACE inhibitor / ARB, beta blocker, mineralocorticoid receptor antagonist, SGLT2 inhibitor, hydralazine / nitrate, ivabradine, vericiguat). Diuretic and volume plan (loop diuretic adjustment, thiazide augmentation, fluid restriction, sodium restriction, daily weights, dry weight target, potassium monitoring, congestion precautions). Blood pressure and heart rate plan. Renal and electrolyte monitoring plan. Device plan (ICD / CRT evaluation, interrogation, biventricular pacing optimization, generator status, arrhythmia review, EP referral). Ischemic or valvular evaluation plan. Advanced heart failure plan (CPET, right heart catheterization, transplant evaluation, LVAD evaluation, inotrope management, pulmonary hypertension evaluation, frailty / nutrition review, psychosocial assessment). Anticoagulation or thromboembolism plan. Lifestyle and self-management plan. Referral and coordination plan. Patient education...

F FOLLOW-UP

10 REASSESSMENT PLAN

Follow-up timeframe and purpose (volume reassessment, medication titration, lab monitoring, BP / weight review, device review, imaging or test result review, post-hospital follow-up, advanced therapy evaluation, transplant / LVAD planning):

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

COUNSELING / COORDINATION OF CARE TIME

RECORDS REVIEW TIME, IF APPLICABLE

DEVICE / TEST REVIEW TIME, IF APPLICABLE

ADVANCED THERAPY COORDINATION TIME, IF APPLICABLE

BASIS FOR BILLING: TIME-BASED / MDM / DEVICE REVIEW / TEST INTERPRETATION / CARE COORDINATION

E/M LEVEL: 99203 / 99204 / 99205 / 99213 / 99214 / 99215

DEVICE INTERROGATION CODE(S), IF APPLICABLE

DIAGNOSTIC TEST INTERPRETATION CODE(S), IF APPLICABLE

CARE COORDINATION CODE(S), IF APPLICABLE

PRIMARY ICD-10 DIAGNOSIS CODE + DESCRIPTION

SECONDARY ICD-10 DIAGNOSIS CODE(S), IF APPLICABLE

SO PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: HEART FAILURE / ADVANCED HEART FAILURE CARDIOLOGY

DATE

TIME