Going Home: What You Need to Know

Admission

Date of admission _____
Reason for admission _____

What was done during this hospital stay:

❑ Testing and monitoring ❑ Surgery ❑ Rehabilitation ❑ Other _____

Discharge

Date patient will be discharged _____

Diagnosis at discharge _____

Medications at discharge (you can use the medication form to help you organize the list of medication your family member is prescribed upon discharge)

Does the patient need to have someone accompany him or her home? ❑ Yes ❑ No

If yes, who will that person be? _____

How will the patient get home?

❑ Private car / taxi ❑ Public transportation (such as subway or bus)

❑ Paratransit (such as Access-a-Ride) ❑ Ambulance

❑ Other _____

Are plans made for this transportation? ❑ Yes ❑ No

If yes, date and time of transportation: _____

Cost: _____

Services and Supplies

Medical Equipment

Does the patient need special medical equipment or supplies? ❑ Yes ❑ No

If yes, what type of medical equipment? (Check all that apply)

❑ Cane
❑ Colostomy care supplies
❑ Wheelchair
❑ Oxygen
❑ Hospital bed
❑ IV setup
❑ Walker
❑ Respirator
❑ Other (such as diapers or disposable gloves)

Was this medical equipment ordered? ❑ Yes ❑ No

If yes, from where? _____

Telephone number: _____

Plans for delivery: _____

Special instructions: _____

Other notes (rental, co-pay, delivery): _____

Home Care Services

Is the patient being referred for home care services? ❑ Yes ❑ No

If yes, what type? (Check all that apply)

❑ Nursing (for medical tasks like wound care)
❑ Physical therapy (PT)
❑ Occupational therapy (OT)
❑ Speech therapy
❑ Home health aide (attendant)
❑ Other (such as Meals on Wheels) _____

Name of home care agency: _____

Telephone number: _____

Date and time of first visit: _____

Reason for this visit: _____

Follow Up

Special Foods and Diet

Does the patient need any special foods or diet? ❑ Yes ❑ No

If yes, what foods or diet? _____

Are there limitations on activity, such as bathing or lifting heavy items? ❑ Yes ❑ No

If yes, what are these limitations? _____

Notes and questions: _____

Medical Tests

Did the patient have any medical tests (for example, CT-scan, X-rays, blood or urine tests) for which you don't have results? ❑ Yes ❑ No

If yes, what are these tests? _____

Test 1. When should this test result be ready? _____

Who should I call for the result? _____

Test 2. When should this test result be ready? _____

Who should I call for the result? _____

_____

If there are more tests for which you do not have results, please attach a separate sheet with the information as shown above.

Appointments

Does the patient have any follow-up appointments outside the home? ❑ Yes ❑ No

If yes, please answer these questions for each appointment:

1. Follow-up appointment

Who is the appointment with? _____

What is the reason for this appointment? _____

What date is the appointment? _____

What time is the appointment? _____

Where is the appointment? _____

Telephone number for the appointment: _____

How will the patient get to the appointment (transportation)? _____

Notes and questions:

_____

_____

2. Follow-up appointment

Who is the appointment with? _____

What is the reason for this appointment? _____

What date is the appointment? _____

What time is the appointment? _____

Where is the appointment? _____

Telephone number for the appointment: _____

How will the patient get to the appointment (transportation)? _____

Notes and questions:

_____

_____

If there are more follow up appointments, please attach a separate sheet with the information as shown above.

Family Caregiver Notes

Questions? Concerns? Please call the discharge planner or health care team member who helped make this plan.

You can reach this person at _____

Other notes: _____

Name of family caregiver: _____

Name of discharge planner who helped make this plan: _____

Date this plan was made and discussed: _____