DISCHARGE PREPARATION CHECKLIST

Patient: _____

Before I leave the care facility, the following tasks should be completed:

- [ ] I have been involved in decisions about what will take place after I leave the facility.

- [ ] My doctor or nurse has answered my most important questions prior to leaving the facility.

- [ ] I understand where I am going after I leave this facility and what will happen to me once I arrive.

- [ ] I have the name and phone number of a person I should contact if a problem arises during my transfer.

- [ ] I understand what my medications are, how to obtain them and how to take them.

- [ ] I understand the potential side effects of my medications and whom I should call if I experience them.

- [ ] I understand what symptoms I need to watch out for and whom to call should I notice them.

- [ ] I understand how to keep my health problems from becoming worse.

- [ ] My family or someone close to me knows that I am coming home, is available to care for me and knows what I will need once I leave the facility.

- [ ] If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

- [ ] I have what I need at home (medication, equipment, home modifications).

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CARE**ABOUT** **YOUR**CARE

MY CARE TRANSITION PLAN

I was in the hospital because:

_____

Patient: _____ Date: _____

Dates of hospitalization: _____

! If I have the following problems...

_____
_____
_____

I should:

_____
_____
_____

My next appointments:

With _____

Address _____

Date/Time _____ Phone _____

With _____

Address _____

Date/Time _____ Phone _____

With _____

Address _____

Date/Time _____ Phone _____

Things to talk to my doctor about at my next visit:

_____
_____
_____
_____
_____
_____

Important contact information:

My primary doctor

Name _____ Phone _____

My hospital doctor

Name _____ Phone _____

My hospital nurse

Name _____ Phone _____

My care coordinator/care manager

Name _____ Phone _____

My visiting nurse or home health care provider

Name _____ Phone _____

My pharmacy

Name _____ Phone _____

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CARE**ABOUT** **YOUR**CARE

MY CARE TRANSITION PLAN

Patient: _____

Last updated: _____

Note what the medication does. For example: **lowers blood pressure** or **for pain relief**

Include any special instructions for the medication, such as **take with food** or **stop taking on 1/14**

Use the grid below to write down the amount you take in each time slot (for example, 1 in the morning and 1 ½ at bedtime).

My daily medications list:

Name	What it does	How to take	Amount to take and when to take			
			Morning	Noon	Evening	Bedtime

As-needed medications:

Name	What it does	How to take	How much and how often

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CARE**ABOUT** **YOUR**CARE