

Ready, Set, Go Home

DISCHARGE GUIDE



Visiting Angels®
LIVING ASSISTANCE SERVICES



The *Ready, Set, Go Home Discharge Guide* provides information to support and assist you and your family with the discharge process, and at home throughout the care continuum.

Greetings from the Visiting Angels Care Team

Whatever the cause for your recent hospital stay, the good news is you are ready to be discharged to the comfort of your own home.

Transitioning from the hospital or rehab to home may seem overwhelming as you consider moving from a setting of around-the-clock care, to managing your care with the help of family, friends and, in some cases, skilled nursing and other therapies. While well enough to return home, you may not have completely recovered.

When you are ready to leave, your hospital or rehab team will provide you with printed instructions about how to manage your care at home.

Far too often people underestimate the assistance needed to continue on the road to recovery. As a result, the recovery period stops with many individuals returning to the hospital or emergency room. Of course, we always think this will not happen to us. However, approximately 20% of patients (that's 1 in 5 people) over the age 65 are readmitted to the hospital within 30 days of discharge.

For that reason, our caring and compassionate Angel caregivers are ready to assist with your recovery, and support you and your family in the comfort of your home.

We honor the ability to care for you in your home and recognize we are guests; your goal is our goal.



APPROXIMATELY 20% OF PATIENTS...
OVER THE AGE 65 ARE READMITTED TO THE
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How Do I Use this Guide?

While you are in the hospital or rehab:

Ask the important questions outlined in this guide so that you are better prepared when you go home. Record vital information as you discuss discharge plans with your health care providers.

Identify areas where you may need some assistance and determine who (family, friends, neighbors and/or Visiting Angels) can assist and coordinate your home care recovery program.

When you get home:

Keep your *Ready, Set, Go Home* Discharge Guide handy and near the phone to use as your care reference with important information, notes from the hospital/rehab, medication list, phone numbers etc.

When you have your follow-up appointments:

Bring along your *Ready, Set, Go Home* Discharge Guide to medical appointments to maintain a comprehensive update on your progress and remind you of questions or comments to make to your doctor. You also can use the guide to record further instructions from your doctor.

When family and loved ones want to know:

Keep this guide available for your family and loved ones so you are well prepared to answer their questions.



My Hospital/Rehab/Nursing Home Information

Name of hospital: _____

I was admitted to the hospital on (date): _____

I was discharged from the hospital on (date): _____

Name of nursing home/rehab facility: _____

I was admitted to the nursing home/rehab facility on (date): _____

I was discharged from the nursing home/rehab facility on (date): _____

The main reason(s) for my hospitalization and/or rehab/nursing home admission were: _____

Surgery date (if applicable): _____

My primary care providers (PCPs) while I was a patient at the hospital or rehab/nursing home were (physicians, nurse practitioner, other):

Name and Title: _____

Contact Number: _____

Home Management

Areas that concern me most about going home or where I may need help are (check all that apply):

	Concern	Need Help
I don't understand how to manage my disease.	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about pain.	<input type="checkbox"/>	<input type="checkbox"/>
Getting to appointments	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining my medications	<input type="checkbox"/>	<input type="checkbox"/>
Managing my medications (refills/reminders)	<input type="checkbox"/>	<input type="checkbox"/>
Paying for my medications	<input type="checkbox"/>	<input type="checkbox"/>
Social support	<input type="checkbox"/>	<input type="checkbox"/>
Getting to Religious events	<input type="checkbox"/>	<input type="checkbox"/>
Getting to social activities	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>
Meal planning	<input type="checkbox"/>	<input type="checkbox"/>
Shopping (food, pharmacy, errands)	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Falling	<input type="checkbox"/>	<input type="checkbox"/>
Caring for a loved one	<input type="checkbox"/>	<input type="checkbox"/>
Household chores (cleaning, laundry)	<input type="checkbox"/>	<input type="checkbox"/>

Other concerns (list) _____

My top three goals when I get home are:

1. _____
2. _____
3. _____

Who can assist me when I get home in the areas where I identified as needing help and with my goals?

Name and Title: _____

Contact Number: _____

Name and Title: _____

Contact Number: _____

Visiting Angels Care Team/Name: _____

Contact Number: _____



My Health Management

Who should I call if my symptoms or condition worsen?

Name and Title: _____

Contact Number: _____

Name and Title: _____

Contact Number: _____

Name and Title: _____

Contact Number: _____

Who should I contact if my symptoms worsen after hours?

Name and Title: _____

Contact Number: _____

Name and Title: _____

Contact Number: _____

Name and Title: _____

Contact Number: _____

When should I or someone caring for me call 911? If in doubt, check it out!

The following signs may indicate a serious event and require a call to 911. This is not a complete list.

- You have chest pain.
- You have slurred speech or find it hard to speak. Your loved ones can't understand what you are saying because your words sound jumbled.
- You have a sudden weakness of your arms or legs.
- Falls resulting in injuries, head injuries, uncontrolled bleeding, other injuries.
- You have severe or unresolved pain. Your medications are not helping.
- You become very sleepy or drowsy.
- You have difficulty breathing—not relieved with medications or rest.



Activities and Diet

Can I resume my normal activities at home?

- Yes
- No

If no, what are my restrictions based on instructions from my Medical provider? _____

Can I resume my regular diet at home?

- Yes
- No

If no, what are my restrictions based on instructions from my Medical provider? _____

I will need help in this area:

- Yes
- No

Our Visiting Angels Care Team can help you with meal preparation, shopping and adherence to your diet.

Equipment, Supplies and Services

Has your physician or other health care provider ordered any of the following?

	Need	I Will Need Assistance With
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Safety Rails	<input type="checkbox"/>	<input type="checkbox"/>
Grab Bars	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Bed	<input type="checkbox"/>	<input type="checkbox"/>
Transfer Lift	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Abduction Pillow	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Brace	<input type="checkbox"/>	<input type="checkbox"/>

Other (list) _____

Who provides my equipment?

Durable Medical Equipment (DME) Company

Name: _____

Contact Number: _____

Other Provider

Name: _____

Contact Number: _____

Who will pay for my equipment/supplies?

DME Company

Home Health Care Agency

Hospice Agency

Insurance

Private Pay (myself)

Other (specify) _____

Home Services

Has your physician or other health care provider recommended any of the following services upon your return home?

Skilled Nursing

Name: _____

Contact Number: _____

Respiratory Therapy

Name: _____

Contact Number: _____

Social Work

Name: _____

Contact Number: _____

Speech/Language Pathology

Name: _____

Contact Number: _____

Physical Therapy

Name: _____

Contact Number: _____

Hospice Services

Name: _____

Contact Number: _____

Occupational Therapy

Name: _____

Contact Number: _____

Adult Day Care

Name: _____

Contact Number: _____

Has an assessment been scheduled?

Yes

Date: _____

Time: _____

No

Visiting Angels of _____

Contact Number: _____

Follow-Up Appointments

Your health and ability to stay home may depend on how well your physician and other health care providers know your current state of health. Do not take the chance of missing something important because you thought it was trivial or did not want to bother anyone.

As part of your ongoing recovery and in an effort to maintain your health, it is important that you:

1. Keep your follow-up appointments with your health care providers.
2. Prepare for your appointments.

What questions should I ask when I go to my medical appointments?

The *Ready, Set, Go Home* Discharge Guide outlines some questions for you to think about before your next appointment. As stated earlier, take this guide with you to your appointments.

I am most concerned about: _____

I have noticed the following symptoms and changes in my condition: _____

Are these symptoms normal for my condition? _____

Describe any pain issues: _____

Share medication issues/questions: _____

Is medicine being changed? If so, why? _____

Special instructions for taking new medications: _____

Are there any side effects? _____

Test results: ask about all test results (lab, radiology, other). What do the results mean? _____

Follow-up instructions: _____

Additional tests required (when): _____

Appointments

Note: If you need support in getting ready for your appointment, escorted to your appointment, and following up with pharmacy and shopping errands after the appointment, our Visiting Angels Care Team can help.

I will need help in this area: Yes No

Appointment Name/Type (doctor, therapy, rehab, etc)

Has this appointment been made? Yes No If no, who do I call to make the appointment?

Name: _____ Contact Number: _____

Appointment Date: _____ Time: _____

Location/Address: _____

Is transportation arranged? Yes No

Who will accompany me to the appointment? _____

Special instructions: _____

Appointment Name/Type (doctor, therapy, rehab, etc)

Has this appointment been made? Yes No If no, who do I call to make the appointment?

Name: _____ Contact Number: _____

Appointment Date: _____ Time: _____

Location/Address: _____

Is transportation arranged? Yes No

Who will accompany me to the appointment? _____

Special instructions: _____

Appointment Name/Type (doctor, therapy, rehab, etc)

Has this appointment been made? Yes No If no, who do I call to make the appointment?

Name: _____ Contact Number: _____

Appointment Date: _____ Time: _____

Location/Address: _____

Is transportation arranged? Yes No

Who will accompany me to the appointment? _____

Special instructions: _____

Medications

Taking medications as prescribed by your physician is an important part of your treatment plan. Unfortunately, people often make the mistake of stopping their medications for a few reasons:

- Do not believe the medication is helping.
- Do not like the side effects.
- Start to feel better and think they no longer need the medication.
- Forget to take medication.
- Medication cost too much.

Medication issues are one of the leading reasons for re-admission to the hospital.

Whether you just miss an occasional dose or stop taking your medications, the result can be the same: a visit to the emergency room or another hospital stay. Our Visiting Angels Care Team can help.

Discuss your concerns with your health care provider or pharmacist first. He or she may be able to give you additional options while continuing to maintain your best health.

I have a copy of my current medication list: Yes No

I understand how to get my medications from the pharmacy (pick-up or delivery): Yes No

Who will pick up my medications?

Name and Title: _____

Contact Number: _____

I will need help in this area: Yes No

Who pays for medication? Self-pay Insurance Other _____

It is important to have an accurate list of current medications. Create a list and take it with you to your health care appointments. Update the list, as needed. Be sure to include all non-prescriptions (over-the-counter) medications and vitamins .

Our Visiting Angels Care Team can help.

WITH PROPER CARE AND PLANNING, YOU CAN REDUCE THE RISK OF RE-HOSPITALIZATION.

Invest in your health and wellness by taking the appropriate measures at home to manage your health.
Use the Visiting Angels' *Ready, Set, Go Home* Discharge Guide as the first step to taking care of yourself.

Medication List

Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements

What I'm Using Rx – Brand & generic name; OTC – Name & active ingredients	What It Looks Like Color, shape, size, markings, etc.	How Much	How to Use / When to Use	Start / Stop Dates	Why I'm Using / Notes	Who Told Me to Use / How to Contact
Ex: XXXX/xxxxxx	20 mg pill; small, white, round	40 mg; use two 20 mg pills	Take orally 2 times a day / 8 am & 8 pm	1-15-11	Lowers blood pressure; check blood pressure once a week; blood test on 4-15-11	Dr. X (800) 555-1234
1						
2						
3						
4						
5						

Medication List

Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements

What I'm Using Rx – Brand & generic name; OTC – Name & active ingredients	What It Looks Like Color, shape, size, markings, etc.	How Much	How to Use / When to Use	Start / Stop Dates	Why I'm Using / Notes	Who Told Me to Use / How to Contact
Ex: XXXX/xxxxxx	20 mg pill; small, white, round	40 mg; use two 20 mg pills	Take orally 2 times a day / 8 am & 8 pm	1-15-11	Lowers blood pressure; check blood pressure once a week; blood test on 4-15-11	Dr. X (800) 555-1234
6						
7						
8						
9						
10						

Medication List

Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements

What I'm Using Rx – Brand & generic name; OTC – Name & active ingredients	What It Looks Like Color, shape, size, markings, etc.	How Much 20 mg pills; small, white, round	How to Use / When to Use 40 mg; use two 20 mg pills	Start / Stop Dates Take orally 2 times a day / 8 am & 8 pm	Why I'm Using / Notes 1-15-11	Who Told Me to Use / How to Contact Dr. X (800) 555-1234
Ex: XXXX/xxxxxx						
11						
12						
13						
14						
15						

Medication List

Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements

What I'm Using Rx – Brand & generic name; OTC – Name & active ingredients	What It Looks Like Color, shape, size, markings, etc.	How Much	How to Use / When to Use	Start / Stop Dates	Why I'm Using / Notes	Who Told Me to Use / How to Contact
Ex: XXXX/xxxxxx	20 mg pill; small, white, round	40 mg; use two 20 mg pills	Take orally 2 times a day / 8 am & 8 pm	1-15-11	lowers blood pressure; check blood pressure once a week; blood test on 4-15-11	Dr. X (800) 555-1212
16						
17						
18						
19						
20						

Notes

Notes

Notes



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The *Ready, Set, Go Home Discharge Guide* provides information to support and assist you and your family with the discharge process, and at home throughout the care continuum.



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