Dear Patient:

Many people need some help when they return home after a hospital stay. We want to have everything that you need arranged when you are ready to leave the hospital. You can help us by giving us the information listed below. Please print this form and fill in as much information as you can and bring it with you when you are admitted to the hospital. This information will help us as we talk with you and your loved ones about your needs. We want to put the best plan in place for when you leave Huntington Hospital.

Thank you,
Your Huntington Hospital Care Coordination Team

Information provided by:
❑Patient ❑Spouse ❑Significant other ❑Son/Daughter ❑Friend ❑Caregiver
❑Mother ❑Father ❑Guardian ❑Other:____

Is the patient a visitor to the area? ❑No ❑Yes, **from**____
City State

What was the patient's living situation prior to this hospitalization? (Please check ALL that apply):
❑Home ❑Alone ❑With Spouse ❑With Significant Other ❑Family ❑Friend
❑Retirement Facility ❑Assisted Living Facility ❑Skilled Nursing Facility
❑Long-Term Acute Facility ❑Sub-acute Facility ❑Board and Care
❑With Parent/Guardian ❑Foster Care ❑Other:__________________________________
Specific information you would like to give about the living situation:
____

How many hours per day is the patient alone?____

Are there children at home that require care by the patient? ❑No ❑Yes

Will the patient need help after discharge? ❑No ❑Yes Comments:__________________________________

Have caregivers been hired to help the patient at home? ❑No ❑Yes
If yes please give contact name and number:____

Present in the patient's home (Please check ALL that apply):
❑Stairs ❑Steps inside the home ❑Steps outside the home Number of steps________________

Accommodations in the patient's home (Please check ALL that apply):
❑Elevator ❑Ramp ❑Railing on stairs or steps ❑Safety grab bars in shower
❑Safety grab bars in Bathroom ❑Other:____

Equipment already in the patient's home (Please check ALL that apply):
❑Hospital bed ❑Walker ❑Single-point cane ❑Quad-point cane
❑Wheelchair ❑Manual wheelchair ❑Electric Wheelchair ❑Crutches
❑Toilet riser ❑Bed-side Commode ❑Shower Chair ❑Reacher
❑Oxygen ❑Breathing Machine ❑Ventilator ❑Suction Machine
❑Apnea Monitor ❑Nebulizer Machine ❑Other:____
Please give contact name(s) and number(s) for the companies that provide this equipment:
____

Pharmacy name and number that the patient usually uses:_______________________________________

Services that the patient used prior to this hospitalization:
❑Home health nurse ❑Home health aide ❑Home delivered meals ❑Housekeeper ❑Transportation
❑Dialysis ❑Wound care at home ❑Wound care at a center ❑IV therapy
❑Respiratory therapy ❑Occupational therapy ❑Physical therapy ❑Speech therapy
❑Hospice ❑Adult daycare ❑Social Worker ❑Case Management
Please give agency contact name(s) and number(s):____
____