

My After Nursing Home Care Plan

**** Bring this Plan to ALL Appointments****

My Name: _____

Discharge Date: _____

Do you have a question or problem about this packet?

Call our nursing home's Care Team: _____

Phone Number: _____

Serious health problem?

Call Dr. _____

Phone Number: _____

This material is adapted based on materials from Agency for Healthcare Research and Quality (AHRQ), Project RED (Re-engineered Discharge), and the Coleman Transitions Intervention in support of the Special Innovation Project: Improving Nursing Home Discharges Back to The Community Implementation Guide.

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To use this guide you should:

- Talk with the nursing home staff about each of the items that are listed in the guide.
- Take the completed guide home with you. It will help you to take care of yourself when you go home.
- Share the guide with your family members and others who want to help you. The guide will help them know how to help take care of you.
- Bring the guide to all of your doctor appointments so the doctor knows what you have been doing to care for yourself since you left the nursing home.
- Have the guide available when you receive the follow up phone call from our nursing home's care team

What is my medical problem?

What are my medication allergies?

Where is my pharmacy?

What exercises are good for me?


What should I eat?


What activities or foods should I avoid?


What medical equipment should I use at home?

Follow this schedule **EACH DAY:**

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Morning				

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Morning				

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
<div style="text-align: center;">  Noon </div>				

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Evening				

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Bedtime				

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
These are medications you only take if needed				
Only if you need it for				

**** Bring this Plan to ALL Appointments****

My Name: _____

When are my appointments?

Date and time of appt		
Provider name		
Provider site information		
Reason for appt		
Provider phone number		

Questions / Concerns

For my appointment with:

PCP Name: _____

Check the box and write notes to remember what to talk about with your PCP.

My pending test results: _____

I have questions about:

My medicines: _____

My pain: _____

Other Concerns:

- I am having trouble with the stairs in my home.
- Someone I live with smokes.
- I feel stressed or overwhelmed.
- I am having trouble getting food.
- There are other things going on in my life that are affecting my health.

What other questions do you have?

Notes about my medical problem:
