



MACOMB

READMIT PREVENTION CALL BACK

Patient Name: _____ A# _____ MR# _____ DOS: _____ Discharge: _____

Patient Phone Number: _____ Surgery: _____ Surgeon: _____ Cards: _____

Stapled Discharge Rx List & Follow-up appointments to this form; HF Call Back Form Completed Done NA

RISK ASSESSMENT:

Any Hx Non-compliant: <input type="checkbox"/> Yes <input type="checkbox"/> No	COPD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Homeless/no insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Home O2: <input type="checkbox"/> Yes <input type="checkbox"/> No	Systolic / Diastolic
Age: >80 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Inhalers: <input type="checkbox"/> Yes <input type="checkbox"/> No	EF: _____%
Lives alone: <input type="checkbox"/> Yes <input type="checkbox"/> No	FEV1%: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>*If HF yes, Fill out HF callback form to be scanned into chart using surg admit A#</i>
Support System: <input type="checkbox"/> Yes <input type="checkbox"/> No	DM: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diuretics <input type="checkbox"/> Yes <input type="checkbox"/> No
Sedentary/Immobile: <input type="checkbox"/> Yes <input type="checkbox"/> No	IDDM: <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Na+ Diet: <input type="checkbox"/> Yes <input type="checkbox"/> No
Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former	HGBA1C >8: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Scale at home: <input type="checkbox"/> Yes <input type="checkbox"/> No
Quit: mo./yr. _____	Misc. concerns: _____	

1st Call Back Date 24 hrs/then min q week: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____ #6 _____ #7 _____

DIACHARGE LOCATION:

SAR/IPR (circle one) Co Name: _____ Unit: _____ Phone #: _____

HC ordered to begin after discharge for IPR/SAR Which HHC Co. name: _____

Discharged Home- HHC Co Name: _____ Name Primary Care Giver: _____
If no HHC state why: _____

DISCHARGE HOME DIALOGUE 1st CALL DATE DUE:

- When did home care see you? _____
- What HC Company?: _____
- What Telemedicine equipment do you have? _____
- Who is helping you at home? _____
- Did you fill all your medication scripts? Yes No
- What Medications are you taking (compare discharge Rx list)
- Are you checking your weight & temp daily? Yes No
- Wt today: _____ Temp Today: _____
- What should you do if you gain 3 pounds in 2 days? correct
- What diet are you following: _____
- What is your appetite like? Good Fair Poor
- How much fluid are you drinking daily? _____
How often are you showering? Daily _____
- When are you wearing support socks? _____
- “ “ “ “ mammary support (if indicated) ATC
- How are you dressed today? Dressed PJ's
- Describe your incisions _____ CDI
- How much are you smoking? _____
- Describe any SOB? _____
- When are your follow-up appointments? (compare to DC list)

SAR/IPR DIALOGUE:

- List any medication changes?
- List any medications not taking?
- Vital Signs?
T _____ HR _____ BP _____
- Describe incisions? CDI

- What is the showering schedule?
 Daily _____
- Remind pt to follow up with Telemedicine at discharge & give #1-800-xxx-xxxx Done
- Anticipated date of discharge?
- Start Date: _____

IPR/SAR Comments/Concerns:

- Call Back Copy to HF clinic NP's
- Progress note to MR

DIALOGUE for FOLLOW-UP CALLS

DATES

COMMUNICATION NOTES:

DIALOGUE for FOLLOW-UP CALLS	DATES
1- How are you feeling today?	
2- When was your last HC visit?	
3- When is your next HC visit?	
4- Are you taking all your Rx?	
5- Are you using Telemedicine Equipment?	
6- Incisions Clean Dry – Red or Tender?	
7- Any questions?	
8- Last Weight	
9- HC Comments/Concerns:	
10- Any readmission: When?:	Where?:
	Why?:

COMMUNICATION NOTES: