McLaren Flint
PATIENT AND FAMILY DISCHARGE/TRANSITION GUIDE

Your Plan for Help at Home

☐ Healthcare Partner: (Name & Contact Information Below)

____

☐ Home Care: (Include Company & Contact Information Below)

____

☐ Preferred Pharmacy: ______________________________

☐ Meals on Wheels: (Include Company & Contact Information Below)

____

☐ Medical Equipment: ____________________

☐ Oxygen: ____________________

☐ Skilled Nursing Facility: (See Attached Package)

☐ Hospice: ____________________

☐ Community Services: ____________________

☐ Other: ____________________

Initial, Date & Time: _________ Initial, Date & Time: _________ Initial, Date & Time: _________

Medication Education

During your stay here, you will be educated on medications given to you. In your written discharge instructions you will receive a list of medications your physician wants you to continue after your hospitalization. Your discharging nurse will review this list with you and you are encouraged to ask them any questions. It is important to understand why you are taking each medication and the potential side effects.

☐ Medication Reviewed ☐ Medications Side Effects Review

Initial, Date & Time: _________ Initial, Date & Time: _________ Initial, Date & Time: _________

Signs and Symptoms You and Your Family Should Watch For:

After leaving the hospital, call your doctor if any of the following occurs:

☑ **Worsening or persistent symptoms**

☑ **Pain not relieved by medication prescribed**

☑ **Unable to eat or drink**

☑ **Other pertinent signs and symptoms:**

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____

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See attached patient discharge instructions for additional signs and symptoms.

Initial, Date & Time: _________ Initial, Date & Time: _________ Initial, Date & Time: _________

*Follow-Up Appointments

Please refer to patient discharge instructions for appointments.

WHITE COPY: PATIENT
YELLOW COPY: CHART

PATIENT AND FAMILY DISCHARGE/
TRANSITION CHECKLIST
17363 12/16

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PT.

MR.#/RM.

DR.