Pre-Encounter Synopsis

(Post-Hospital/Pre-Home Visit)

Patient Name:	DOB (MM/DD/YEAR):	MRUN:
Location of Hospitalization:	Admission/Discharge Date:	Patient discharged to:
PCP/ RN3:	PCMH (Empaneled or last seen/seen most often):	Date of CHW review:
Medical records available for review? Y/N If no- why not? Is medical release from patient necessary to obtain records? Y/N		

Review of Admission Documents (in ORCHID or from outside records)
1. Main reason for patient hospitalization?
2. Was the hospitalization preventable? Yes No
3. What procedures/tests did patient have in the hospital?
4. What were the key medication changes made pre discharge?
5. What treatment recommendations were made?
6. Were any home services set up? eg oxygen, home antibiotics, wound nurse?
7. What follow up appointments were recommended and when are they supposed to happen?

8. List “red flags” or danger signs that indicate disease state is worsening: a. b. c. d. e.
9. Identify WRAPS to be reviewed with patient a. b. c. d. e.

10. Key thing to coach patient around:	11. What does RN3 or PCP want you to look for when you do home visit?
12. Make/list appointments with PCP and specialists:	13. Make/list appointments for lab test/Xrays:

Form Reviewed With:	*CHW Name:*	*Date of Review:*
Home Visit Address:		*Date of Home Visit Scheduled[1]:*

[1] *Home visit should be made within 48 business hours of discharge.*

Transitions of Care: HOME VISIT FORM

CHW Name: _____ *PCP:* _____

Patient Name:	Address/location:
Home Visit Date:	Patient Phone #:
Patient Emergency Contact Name :	Patient Emergency Contact Phone Number:

A. Document patient responses to following Qs:

1. Why were you hospitalized?
2. What happened while you were there?
3. Did any of your medications change?
4. Are you doing anything differently now in terms of how you are taking care of yourself?
5. Has anything else changed?
6. What are you most worried about since you came home?
7. Do you know if you are supposed to have any appointments or testing soon? When/where?
8. How are you feeling emotionally about everything that happened?

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9. How are you feeling today? Better Same Worse *(If worse, notify PCP)*
   Comments:
10. If you have a wound/if you've had surgery…how is healing?
11. Are you able to do daily activities, such as getting dressed, moving around, washing, and getting food for yourself? Describe and note any limitations, if any.

DMEs

12. Were you discharged home with medical equipment? YES NO

IF YES, describe the medical equipment received:

IF NO, do you need medical equipment? YES (describe, if so) NO

13. Are you receiving any home health agency services? YES NO NA

IF YES, list services/providers

IF NO, do you think you need any home services? YES (Describe) NO

Support Network

14. Do you have friends/family to help? ☐ YES ☐ NO ☐ NA

☐ YES ☐ NO ☐ NA

15. Do you have other help or assistance at home?

Describe:

16. Is there anything else troubling you?

17. Are you having any issues with:

Housing
Transportation
Health insurance status
Food
Child Care
Filling your medications?
Other?

B. Do Medication Review

C. Review Wrap Plans

Topic	Check if Delivered	Check if Understood[1]	Write in questions or concerns

[1] *Assess by using various methods, such as Ask-Tell-Ask.*

_____

Follow-Up Appointments and Labs

D. Document and review upcoming appointments with the patient

☐ Do pre-visit prep form

☐ Decide on outpatient appointment for which you will accompany patient

E. Complete patient worksheet and give to patient

F. Have patient sign any necessary releases

General Comments:

COMPLETED BY: _____ DATE: _____

Discharge FROM:	Discharged TO:
Name/type of facility:	Name/type of facility:

Date completed: _____ *Patient Name:*_____

THIS IS WHY I WENT TO THE HOSPITAL: _____

Key things discussed today:

1.

2.

3.

Key medication changes:

1.

2.

3.

Key signs/symptoms to watch out for:

1.

2.

3.

GOALS FOR THE NEXT SIX WEEKS:

My action steps:	CHW action steps:
1. 2. 3.	1. 2. 3.

Date completed: _____ *Patient Name:*_____

FOLLOW-UP APPOINTMENT(S) INFORMATION

Provider Name & Visit Type *(Primary or Specialty)*	**Date of Appointment**	**Time of Appointment**	**Appointment Location (Clinic/Hospital Name & Address)**	**Facility/Provider Phone Number**

Concerns to share and/or questions to ask my provider:

1.

2.

3.

4.

If I have questions, I can call:

1. **My CHW _____ at phone number: _____**
2. **My Nurse Manager _____ at phone number: _____**
3. **My PCP _____ at phone number: _____**

**See PRE-VISIT FORM to be completed with CHW prior to your next visit (bring an extra copy for the patient)*