Orthopedic Patient Discharge Planning Information

PLEASE COMPLETE AND BRING WITH YOU TO THE HOSPITAL ON THE DAY OF YOUR SURGERY

Last Name: _____ First Name: _____

County in which you reside: _____

Who will be your support person in your home? _____

Do you have transportation home after surgery? _____

Which Pharmacy do you use? _____

Do you have any durable medical equipment already in your home (walkers, crutches, canes, commodes etc.)? _____

_____

Number of steps into your home: _____

Layout of your home (bathroom downstairs, upstairs, bedroom downstairs, upstairs etc):

_____

_____

Do you currently or have you had home care services in the past?

_____

Home Care Agency preference: _____

Skilled Rehabilitation Nursing Facility preferences:

_____