St Peter's Health Partners
Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

Care Transitions Visit Guide for Members

Use this sheet to ensure you are capturing all the relevant information when conducting a Care Transition with a Member. Information from this form should be used in the CareManager documentation.

Patient Information	
Member Name:	
Date of Visit: __ __ / __ __ / __ __	**Chart Number:**

Medications	
Does the Member have the medications prescribed to him/her on the Discharge Plan? *If some or none, identify how you can help Member obtain the medications.*	☐ All ☐ Some ☐ None
Notes:	
Does the Member have questions, concerns or confusions surrounding any of the prescribed medications? *If some or all, contact the prescriber, pharmacy or other provider with the Member to alleviate anything noted.*	☐ All ☐ Some ☐ None
Notes:	

Follow-up Appointments	
Is the Member aware of his/her upcoming appointments? *If some or none, ensure the Member is made aware of all appointments.*	☐ All ☐ Some ☐ None
Notes:	
Does the Member have transportation to those appointments? *If some or none, work with the Member to identify options for transportation.*	☐ All ☐ Some ☐ None
Notes:	
Does the Member have concerns or questions about any of the upcoming appointments? *If some or all, contact the provider with the Member to alleviate anything noted.*	☐ All ☐ Some ☐ None
Notes:	

Member Concerns	
Does the Member have any other concerns at this time? *If yes, summarize the concerns and steps taken, or to be taken, to alleviate the concerns.*	☐ Yes ☐ No
Notes:	
Based on today's visit and other information gleaned from the Member's record is a follow-up contact/appointment needed this month?	☐ Yes ☐ No
Notes:	

	Member Concerns: I am concerned about….		NOTES
MEDICAL	Having all the information need when I leave the hospital.	☐ Yes ☐ No	
	Follow up care after leaving the hospital.	☐ Yes ☐ No	
	Scheduling follow up appointments and/or tests.	☐ Yes ☐ No	
	Who to call with questions or concerns.	☐ Yes ☐ No	
	How will I get to my doctors follow-up appointment.	☐ Yes ☐ No	
	The type of medical equipment I will need (i.e., Walker, crutches, insulin pump, oxygen, etc.).	☐ Yes ☐ No	
	Managing my wound care.	☐ Yes ☐ No	
	Paying for the care I need.	☐ Yes ☐ No	
MEDICATIONS	Which medications I should take at home.	☐ Yes ☐ No	
	When to take which medications.	☐ Yes ☐ No	
	Taking the medication as prescribed.	☐ Yes ☐ No	

	Understanding the side effects of my medications.	☐ Yes ☐ No	
	Paying for my medications.	☐ Yes ☐ No	
	Getting my medication from the pharmacy.	☐ Yes ☐ No	
ACTIVITIES OF DAILY LIVING	Getting help with personal care (i.e., bathing, dressing).	☐ Yes ☐ No	
	Cooking meals.	☐ Yes ☐ No	
	Getting help with grocery shopping.	☐ Yes ☐ No	
	Using Medical equipment, changing a bandage, or giving an injection.	☐ Yes ☐ No	
CARE PARTNER	How my family or other caregivers will help me when I am home.	☐ Yes ☐ No	
	How my family or other caregivers will manage my illness.	☐ Yes ☐ No	
	Losing contact with friends and family, and feeling isolated or left behind.	☐ Yes ☐ No	
CULTURE	Whether I will be able to keep my core beliefs and values despite my illness.	☐ Yes ☐ No	

	Social Determinants of Health	Yes	No	Notes
	In the last 12 months, did you ever **eat less that you felt you should** because there wasn't enough money for food?	☐	☐	
	In the last 12 months, has your **utility company shut off your service** for not paying your bill?	☐	☐	
	Are you worried that in the next 2 months, you **may not have stable housing**?	☐	☐	
	Do problems getting **childcare make it difficult for you to work** or make it to appointments?	☐	☐	
	In the last 12 months, have you needed to see a doctor but **could not because of cost**?	☐	☐	
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there**?	☐	☐	
	In the last 12 months, have you not been able to get **medical supplies or medications** when you needed them?	☐	☐	
	Do you ever need help **reading hospital materials**?	☐	☐	
	Are you **afraid you might be hurt** in your apartment building or house?	☐	☐	
	If you checked YES to any box above, **would you like to receive more assistance** with any of these needs?	☐	☐	
	Are any of your needs urgent? For example, I don't have food tonight or I don't have a place to sleep tonight.	☐	☐	