Leaving the hospital sounds simple. But all too often, people find themselves back at the hospital within only a few weeks. With better planning and better communication, many of these return visits can be avoided.

**Why It Could Happen to You**

- You may not be clear about what medicines you should take and when to take them.
- Important information may not make it from the hospital to you or your primary care providers.
- You may have trouble scheduling needed follow-up appointments or getting to the pharmacy.
- You and your primary care providers may not get important test results in time.
- Your family members may not be able to care for you at home.

**WHAT YOU SHOULD KNOW**

- More than a third of us don’t get the tests, referrals or follow-up care we need after a hospital stay.
- Nearly one in five older patients covered by Medicare is readmitted to the hospital within a month of discharge.
- Each year, millions of potentially preventable trips to the hospital add billions to the nation’s health care spending.

**WHAT YOU SHOULD DO**

**ASK AND ASK AGAIN**

Don’t be afraid to bother doctors, nurses and pharmacists with questions and concerns.

**SAY IT BACK**

Repeat the instructions you get in the hospital back to your doctors and nurses to make sure you understand them.

**HAVE A DISCHARGE PLAN**

Make sure you leave the hospital with a detailed, written plan that includes:

- A schedule of follow-up appointments.
- A list of your medical problems.
- A list of your medications, including when to take them and for how long, and any possible side effects.
- A list of equipment you might need, such as a cane or wheelchair. Try to make sure any changes to your home, such as grab bars in the bathroom, have been made or scheduled.

If your hospital doesn’t provide similar tools, use the Care About Your Care discharge checklist and care transition plan.

**MANAGE YOUR MEDICATIONS**

Many people end up back in the hospital because of medication problems. Doctors need to know all the medications you are taking — prescription, over the counter, and vitamins and supplements — to avoid mix-ups and duplications. Get clear oral and written instructions, and then have a family member or friend help go over your medications and ask questions.

Use the medication list in the Care About Your Care transition plan.

**KEEP APPOINTMENTS**

See your primary care provider or specialist as directed after leaving the hospital. Bring your plan, medications, and medication list to each appointment. If you don’t have a doctor or don’t know how to reach the needed specialist, ask hospital staff to set you up with one.

**KNOW WHAT TO DO IF YOU DON’T FEEL WELL**

Know the danger signs for your condition and what you’ll do if your symptoms get worse. Know whom to call during the day, at night and on weekends.
I have been involved in decisions about what will take place after I leave the facility.

My doctor or nurse has answered my most important questions prior to leaving the facility.

I understand where I am going after I leave this facility and what will happen to me once I arrive.

I have the name and phone number of a person I should contact if a problem arises during my transfer.

I understand what my medications are, how to obtain them and how to take them.

I understand the potential side effects of my medications and whom I should call if I experience them.

I understand what symptoms I need to watch out for and whom to call should I notice them.

I understand how to keep my health problems from becoming worse.

My family or someone close to me knows that I am coming home, is available to care for me and knows what I will need once I leave the facility.

If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

I have what I need at home (medication, equipment, home modifications).

This tool was developed by Eric Coleman, MD, MPH, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.
If I have the following problems...

My next appointments:

With
Address
Date/Time	Phone

With
Address
Date/Time	Phone

With
Address
Date/Time	Phone

Important contact information:

My primary doctor
Name	Phone

My hospital doctor
Name	Phone

My hospital nurse
Name	Phone

My care coordinator/care manager
Name	Phone

My visiting nurse or home health care provider
Name	Phone

My pharmacy
Name	Phone

Patient: 

Date: 

Dates of hospitalization: 

I should: 

Things to talk to my doctor about at my next visit: 

I was in the hospital because:
My daily medications list:

<table>
<thead>
<tr>
<th>Name</th>
<th>What it does</th>
<th>How to take</th>
<th>Morning</th>
<th>Noon</th>
<th>Evening</th>
<th>Bedtime</th>
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As-needed medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>What it does</th>
<th>How to take</th>
<th>How much and how often</th>
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Note what the medication does. For example: lowers blood pressure or for pain relief.

Include any special instructions for the medication, such as take with food or stop taking on 1/14.

Use the grid below to write down the amount you take in each time slot (for example, 1 in the morning and 1 1/2 at bedtime).