St. Albans Primary Care

TCM Visit Check List

Patient Name: _____ DOB: _____ *(MM/DD/YYYY)*

Reception

Form Completed by: _____ Date: _____ *(MM/DD/YYYY)*

Source of Information: _____

☐ When was the patient **admitted** to the hospital? _____ *(MM/DD/YYYY)*

☐ When was the patient **discharged** from the hospital? _____ *(MM/DD/YYYY)*

☐ **Where** is the patient being discharged to? Please be specific (home with/without home health care, family member's house, rehabilitation, nursing home, etc.). _____

_____

☐ Has the hospital indicated need for **referrals** (follow up with specialist or additional testing as an outpatient)?

☐ Yes ☐ No ***If yes,*** *please complete table.*

Referral Type	**Has the referral already been made at patient discharge?** ***If yes, please indicate date of patient's scheduled appointment.***
	☐ Yes _____ *(MM/DD/YYYY)* ☐ No
	☐ Yes _____ *(MM/DD/YYYY)* ☐ No
	☐ Yes _____ *(MM/DD/YYYY)* ☐ No
	☐ Yes _____ *(MM/DD/YYYY)* ☐ No

☐ **Schedule the TCM visit.** Note: No appointment should be scheduled prior to **5-7 days** after discharge, unless override has been communicated by provider or nurse.

Date of TCM Visit: _____ *(MM/DD/YYYY)* Provider: _____

Additional Notes:

Please bring this sheet to nursing station mailbox and place in TCM folder.

Patient Name: ..... DOB: ..... *(MM/DD/YYYY)*

Nurse TCM Call

Call Completed by: ..... Date: ..... *(MM/DD/YYYY)*

Discharge summary reviewed? ☐ Yes ☐ No .....

If not, proceed with patient interview portion of form. Complete any deferred questions once summary obtained and reviewed. If deferred questions completed at a later date, please record date and initials next to response.

☐ Discharge Diagnosis: .....

Survey patient's understanding. *"What brought you to the hospital? Can you explain your diagnosis?"*
Describe patient understanding of their diagnosis. ☐ Good ☐ Fair ☐ Poor

Details: .....

☐ Medication List Reconciliation: *"Were you sent home with an updated medication list? Can you tell me how you are taking each medication? Do you have any questions about how to take them?"*

- ☐ Medication list reconciled
- ☐ Patient taking medications as prescribed
- ☐ Patient not taking medications as prescribed
  - ☐ Patient does not have all medications at home
  - ☐ Patient does not understand instructions
  - ☐ Patient is not tolerating the medications

Details: .....

☐ Status of Recovery: *"How are you feeling? Are you experiencing any pain, trouble breathing or moving around? Are you passing urine and having regular bowel movements? Are you on a restricted diet, and if so, how are you tolerating it"?*

Details: .....

☐ Psychosocial Screening: *"Where are you recovering? Do you have any help? Is there anything that is causing you stress at home? Would you like any more help as you recover?"* Please note whether appointment with community care coordinator is indicated.

Details: .....

☐ Fall Risk Screening (65+): *Adopted from MAHC 10.*

- ☐ **History of fall** within 3 months
- ☐ **Incontinence**: "Do you have trouble making it to the bathroom in a timely manner?"
- ☐ **Visual Impairment**: Assess for history of impairment and/or recent decline.
- ☐ **Environmental Hazards** (ie. equipment tubing, hard to reach items, uneven floors)
- ☐ **Impaired Functional Mobility**: Does the patient need help with IADLs or ADLs, have gait/transfer problems, impaired sensation or coordination, pain, arthritis, foot problems?
- ☐ **Cognitive Impairment**: History of impairment and/or recent decline.

☐ Does the patient have necessary referrals scheduled? ☐ Yes ☐ No

Details: .....

Patient Name: ..... DOB: ..... *(MM/DD/YYYY)*

Nurse TCM Call Additional Notes:

Pre-Visit Checklist

- ☐ Discharge summary obtained
- ☐ What tests were ordered during hospitalization? Please check box next to tests that require follow up by provider and ensure that results are available for review prior to visit.
  - ☐ .....
  - ☐ .....
  - ☐ .....
  - ☐ .....
  - ☐ .....