We care about you and your needs.

You and your family are part of our health care team and it is important for you to have a say in decisions affecting you. This will help us plan your discharge better.

Please read the following, check the boxes that apply to you, and give this to your nurse.

**Medications**

I may need help:
- [ ] Paying for my prescriptions
- [ ] I need somebody to drive me to a pharmacy so I can pick up my prescriptions
- [ ] I would like to use the pharmacy at Sacred Heart 474-3088/7-6 weekdays/9-5 weekends
- [ ] New prescriptions ready in approximately 2 hours
- [ ] I don’t understand how to take my medicine at home

I may need information on available resources to help me pay for:
- [ ] My hospital stay
- [ ] My housing, electricity, food
- [ ] My equipment, oxygen, assistance at home

**Equipment**

I may need help obtaining:
- [ ] Equipment
- [ ] Walker or cane
- [ ] Wheelchair
- [ ] Bed
- [ ] Bathroom aids
- [ ] Oxygen or other breathing equipment
- [ ] Safety equipment – changing your home to meet your medical needs

**Transportation**

I may need help getting:
- [ ] a ride home upon discharge
- [ ] a ride to my doctor appointments
- [ ] a ride to my other medical visits or therapy

**Financial**

I may need help with:
- [ ] Stairs, location of bed and bathroom access
- [ ] Ability to move around, walk, move from bed to chair, to bathroom
- [ ] Personal help for bathroom, bathing, dressing, personal care
- [ ] Cooking meals
- [ ] Getting groceries
- [ ] Housekeeping
- [ ] Pets

Who will help you or provide care at home?

________________________

Home Health Care Agency: ________________________

How much help/care can family or friends provide?

# of Hours per Day: _____ # of Hours per Week: _______

Know Me, Care for Me, Ease My Way