HEALTH MINISTRY NETWORK

Faith Based Transitional Care Checklist

Client Name _____

Phone _____ E-mail _____

Caregiver Name_____ Relationship _____

Phone _____ E-mail _____

Checklist completed by _____ Date_____

Printed Name and Title

Help Establish a Safe Healing Environment

____ **Fluids by mouth**; sufficient fluids that result in pale yellow urine output

____ **Food intake**; specialized diet prescribed _____
Check cupboards and refrigerator for adequate nutritious food and/or prescribed diet

____ **Moving safely** without ( ) with ( ) assistance; Avoid prolonged sitting, esp. in a recliner
mobility aids _____

____ **Sleep** (seven hours or more) _____/day _____

____ **Pain level** "4" or less (1-10 pain scale) ____; with ____ without ____ pain medication
Taking pain meds at pre- scheduled times _____ and/or at night for sleep _____-

____ **Elimination** BMs____/day; stool softener/laxative_____

____ **Equipment needed**: thermometer ___, B/P cuff ____, assistive aids (safety bars, bathing aids/
seat ____ , toileting aids/ bars and elevators _____, mobility aids/ cane, walker, wheelchair ____

____ **Deep breathing** every hour or so

____ **Other** _____

Ensure Primary Care Provider (PCP) Follow-up Appointment and Medication Review

____ **Follow-up appointment with PCP**; Name _____

Location _____ Phone _____

Appointment: Date _____ and Time _____

Transportation provided by: _____

____ E**stablish a written medication regimen system** for taking and recording meds from PCP orders;
See *My_Medicine_List/* www.healthministriesnetwork.net/transitional care

____ **Maintain Personal Health Record** for tracking and documentation (on file with PCP); written
PHR available from *Health Ministries Network* and complete the cover information.

Encourage Clients and Caregivers with Emotional and Spiritual Support

_____ **Spiritual History:** *See FICA Spiritual Assessment*

_____ **Meal Assistance**; short term – Meal and freezer ministry; long term -- Meals on Wheels

_____ **Emotional support/Respite care** for caregiver/partner; _____ and/or home helper services____
Contact: *Northwest Regional Council for recommendations and supportive services though Aging and Disability services. (360) 738-2500*

Watch for the "Red Flags"

"Red flags" that need to be reported to the PCP by the **client or caregiver** are signs of medical complications or worsening physical condition, such as:

____ Constipation (24 hours or longer)

____ Increased pain (not well controlled by pain meds)

____ Change in mental status (confusion or disorientation)

____ Bloating, loss of appetite, nausea and/or vomiting

____ Fever (oral temp of 100^{o} F or higher) for 24 hours

____ Unexplained skin rash or redness

____ Unexplained swelling in feet and legs

____ Painful / frequent / urgent urination

____ Incisional redness, swelling, or gaps

Dr. _____contacted: Date_____ Time_____

Faith Based Transitional Care Tool Kit:

____ Home Safety Checklist ____ My Medicine List

___ Personal Health Record ____ PCP Visit Checklist

Plan for Follow up: Phone call _____ Home visit _____

"Improving the health of our community through faith based nurses and health ministers"

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