Post-Discharge Follow-up Report for Diabetes

Patient Information:

Name: Last, First	Date of Birth	SJGH MRN
Physical Address		Phone Number
Insurance Company (For Research only)	Date Discharged	Date of 1st PCP Visit
Date of Follow-up with Specialist	Name of Specialist,	Name of Clinic

Post Discharge Follow-up Provided:

- ☐ Review disease process hand-out from the hospital with patient. Ensure understanding.
  - Did patient already read material? (Circle) YES NO
    - If not, why? Language, small print, hard to understand, not interested, other
- ☐ Review "Hospital in the Home for Diabetes" handout with patient. Ensure understanding.
- ☐ Review "Signs and Symptoms of Hypo/Hyperglycemia" with patient and coach on diet, review of carbs, and monitoring of skin and feet for infection.
- ☐ Review and coach patient and caregiver about MD plan for managing DM complications at home and how to obtain help.
- ☐ Review "Blood Sugar Monitoring Log" or device memory with patient.
  - Has patient kept a log since last visit? Yes / No
  - If not, why?_____
- ☐ Obtain vital signs:
  - B/P: _____ Pulse rate, quality:_____
  - Wounds on Extremities?_____
  - Blood Glucose Level (circle): Fasting / Random. _____
- ☐ Functional status (circle) Bed Bound/ Wheelchair/ Ambulatory with Aid, w/o Aid
- ☐ Code Status (circle): Full code / POLST with limitations / DNR
- ☐ Check Diabetes management supplies. Does patient have strips and lancets? Yes / No
  - Does patient know how to use? Yes / No
  - Brand and Type of device:_____

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- Medication Reconciliation:
  - Does patient use a specific pharmacy? Yes / No
  - Pharmacy name and location:_____
  - Correctly taking medications prescribed at discharge? Yes / No
  - Taking additional medications prescribed by: (circle) PCP / Specialist / None
  - Taking over-the-counter medications: Yes / No
  - Is patient's extra insulin stored in refrigerator? Yes / No
  - Is patient's current insulin stored at less than 80 degrees? Yes / No
  - Does patient already have a Medi-set or pill box organizer? Yes / No
    - Does the patient use the Medi-set or pill box organizer? Yes / No
    - Will patient use a Medi-set or pill box organizer if provided? Yes / No
- Substance Abuse (circle) ETOH / Smoking / Illicit drugs / None
- Does the patient understand dietary recommendations? Yes / No
- Will the patient follow food and diet recommendations? Yes / No
- Does patient use Home Health Services: Yes / No
- Does patient use In Home Supportive Services (IHSS): Yes / No
- Comments from site visit:

- Urgent contact warning made?
  - To whom:_____

Name Date Via

Report By:

_____ _____ _____

Print Name Signature Date