I was hospitalized at ______________________Hospital
from _______ through ________
for the following problems.

__________________________
_____________________________
__________________________
_____________________________

(=In Plain words)

At the time of hospital discharge I have been
diagnosed with:
(=In Medical words)

1. ______________________________________
2. ______________________________________
3. ______________________________________

Other:

________________________________________

While in the hospital, I had the following tests and
procedures.

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________

My Medications at the time of hospital discharge
include the following.

Home medications to be continued...

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________
9. ______________________________________
10. _____________________________________
11. _____________________________________
12. _____________________________________

New medications to be started after hospital
discharge...

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

Home medications to be discontinued...
(STOP TAKING THESE!)

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

If I have the following problems after discharge, I should:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

The tests and issues I need to talk with my doctor(s)
about at my clinic visit are:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
After hospital discharge, I have the following appointments.

1. __________________________
   On ___/__/____ at ___:__ am/pm.
   For ________________________.

2. __________________________
   On ___/__/____ at ___:__ am/pm.
   For ________________________.

3. __________________________
   On ___/__/____ at ___:__ am/pm.
   For ________________________.

4. __________________________
   On ___/__/____ at ___:__ am/pm.
   For ________________________.

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Important Contact Information.

I can call (xxx)xxx-xxx at any time day or night if I have emergent questions. For specific questions, and during daytime hours, I can call the numbers listed below:

Either I or my doctor can call (xxx)xxx-xxxx to obtain these test results after hospital discharge.

1. My primary doctor:
   __________________________
   (___)____________________

2. My hospital doctor:
   __________________________
   (___)____________________

3. My case manager or social worker:
   __________________________
   (___)____________________

4. The hospital nursing unit:
   __________________________
   (___)____________________

5. My visiting nurse:
   __________________________
   (___)____________________

6. My pharmacy:
   __________________________
   (___)____________________

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I have discussed my end-of-life care preferences and/or advanced directives with my medical team, and my preferences are as follows.

☐ In the event that my heart should stop beating or my breathing should fail, I prefer that my medical team allow me to have a natural death (Also known as Do Not Resuscitate status).

☐ I have completed an advance directive, and this document can be found:
   ____________________________________________________________
   ____________________________________________________________

☐ In the event that I am unable to make medical decisions, I would like the following person(s) to make medical decisions for me:
   ____________________________________________________________
   ____________________________________________________________

☐ Legally, this person is my health care power of attorney,

Further Instructions:

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

I will make sure to keep this document handy when I get home, and I will take it to my follow up clinic appointments to help communicate with my other doctors.