READMISSION PREVENTION TOOLKIT

**Follow-Up Phone Call Scripts**

*Phone Interview (Within 3 days and within 7 days after hospital discharge) - Use Teach Back*

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_**

Date of this call\_\_\_\_\_\_\_\_\_\_\_\_ 🞏Within 3 days since discharge 🞏Within 7 days since discharge

Who was interviewed? 🞏Patient 🞏Caregiver/Family Member 🞏Unable to reach on this attempt

Discharge Disposition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Agency/Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Information**

1. Are you/the patient feeling better each day? 🞏 Yes 🞏 No Comment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Were you able to fill your medications?🞏 Yes 🞏 No If unable, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you taking your medications as prescribed? 🞏 Yes 🞏 No If unable, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you have questions/problems regarding your medications? 🞏 Yes 🞏 No Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Symptoms exacerbation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. If Home Health was arranged, has the home health nurse called or visited? 🞏 Yes 🞏 No

7. Do you have a follow-up appointment? 🞏 Yes 🞏 No Follow-up physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you know when your follow-up appointment is? 🞏 Yes 🞏 No Follow-up appointment date: \_\_\_\_\_\_\_\_

9. Will you have problems getting to your follow-up appointment? 🞏 Yes 🞏 No

10. Do you know who to call if you have any problems at home? 🞏 Yes 🞏 No

1. Did you receive a Heart Failure Patient Education Handout? 🞏 Yes 🞏 No

2. Do you have any questions about the information in the Handout? 🞏 Yes 🞏 No

3. Have you had increased lower extremity swelling? 🞏 Yes 🞏 No

4. Have you had any increase in shortness of breath? 🞏 Yes 🞏 No

How many pillows do you need to sleep comfortably or do you sleep sitting up?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you have a scale at home? 🞏 Yes 🞏 No What was your weight this morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been weighing yourself daily? 🞏 Yes 🞏 No If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you gained any weight the past week? 🞏 Yes 🞏 No If yes how many pounds?\_\_\_\_\_\_\_\_\_

6. What is your fluid restriction amount? \_\_\_\_\_\_\_\_\_\_\_\_\_What is your daily sodium restriction?\_\_\_\_\_\_\_\_\_\_

What did you eat today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What fluid pill do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any problems taking it? 🞏 Yes 🞏 No

8. Any other questions or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note:

Patient Label