# CARDIAC SURGERY
# DISCHARGE PLANNING ASSESSMENT

SURGEON: _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____

PHONE _____ E-MAIL _____

1. With whom do you live? ☐ Alone ☐ Spouse ☐ Children ☐ Other
2. Where do you live? ☐ House ☐ Apartment ☐ Lodge ☐ Other
3. Are there stairs in your home? ☐ Yes How many? _____ ☐ No
   How often are they used ☐ Rarely ☐ Once a day ☐ Twice a day ☐ Multiple times a day
4. Who is responsible for these tasks in your household?

| | | | | |
|---|---|---|---|---|
| Cooking | Myself | Spouse | Children | Other _____ |
| Housekeeping | Myself | Spouse | Children | Other _____ |
| Lawn / Yard Care | Myself | Spouse | Children | Other _____ |
| Driving | Myself | Spouse | Children | Other _____ |
| Shopping | Myself | Spouse | Children | Other _____ |
| Banking | Myself | Spouse | Children | Other _____ |

4a. If you are the only one in your household responsible for these tasks, have you made arrangements for assistance with these tasks for the first several weeks of your recovery? ☐ Yes ☐ No

5. Can you perform daily activities (i.e. bathing, dressing, eating, going to the bathroom) without help?
   ☐ Yes ☐ No If no, what help do you need? _____

6. Do you currently use any of the following aids or services? (check all that apply)
   ☐ Hearing Aid(s) ☐ Glasses ☐ Oxygen ☐ BIPAP / CPAP
   ☐ Cane / Crutches ☐ Walker ☐ Wheelchair ☐ Bath Bars / Seat ☐ Raised Toilet Seat
   ☐ DATS / SCATS ☐ Meals on Wheels ☐ Hemodialysis / Peritoneal dialysis
   ☐ Emergency Medical Alert System ☐ Medication packets pre-made by the pharmacy
7. Do you have a shower in your home? ☐ Yes ☐ No
8. Have modifications been made to your home (i.e. grab rails)? ☐ Yes ☐ No
   If yes, please describe _____
9. Have you ever received Home Care services? ☐ Yes ☐ No
   If yes, what type of service did you receive? _____
   Who is your current home care coordinator? _____

10. Have you ever been hospitalized for rehabilitation? (i.e. admitted to the Glenrose, Subacute program)
☐ Yes ☐ No If yes, please explain _____

11. Have you ever fallen down and injured yourself? ☐ Yes ☐ No
If yes, please explain _____

12. Have you ever had a period of confusion or felt mixed up after any type of surgery?
☐ Yes ☐ No If yes, please explain _____

13. Do you currently have problems with your memory or thinking that affect your daily life?
☐ Yes ☐ No If yes, please explain _____

14. Have you ever been diagnosed with any of the following (check all that apply)?

| | | |
|---|---|---|
| ☐ Mini stroke (TIA) | ☐ Stroke | ☐ Alzheimer's / Memory problems |
| ☐ Diabetes | ☐ Kidney problems | ☐ Bowel / Bladder control problems |
| ☐ Irregular heart beat | ☐ High blood pressure | ☐ Arthritis / Joint problems |

15. Do you have drug coverage? ☐ Yes ☐ No
Are you concerned about being able to pay for your drugs when you are discharged from hospital?
☐ Yes ☐ No

16. Do you wish to develop a legal document (Personal directive) which will make your wishes known and / or name an individual to act on your behalf should you become incapable of making your own health care decisions? ☐ Yes ☐ No ☐ Have one already

If you have a personal directive, **bring it to the hospital when you come for surgery**.

17. How do you plan to get home after being discharged from hospital?

_____

Please list the name of your support person who will be taking you home and staying with you for at least one week after surgery.

Name _____
Address _____
Phone _____

18. Please list the name of your family doctor who will be looking after you after your surgery and be responsible for certain medication adjustments.

Name _____
Address _____
Phone _____

19. Do you have any other needs that have not been described above? ☐ Yes ☐ No
If yes, please explain _____

20. Completed by _____