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**Division of Hospital Medicine**

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**Readiness for Discharge Survey**

[ Patient Engaged Discharge Pilot Study ]

|  |  |
| --- | --- |
|  |  |
| Study ID : |  |
| Survey # : |  |
| Date & Time: |  |
| Last Name: |  |
| Room: |  |

**UCSF Division of Hospital Medicine – Patient Engaged Discharge Pilot Survey**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How often do you have someone (like a family member, friend, hospital/ clinic worker or caregiver) help you read hospital materials?
 | ☐ Never | ☐ Occasionally | ☐ Sometimes  | ☐ Often | ☐ Always |
|  Comments: |

Thinking about how things were going before you came to the hospital:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. I understood the purpose of all my medications
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. I had a system to keep track of my medications
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

Now I will ask you about things going on **today**:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you have a catheter in your bladder?
 | ☐ Yes |  | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Have you been out of bed to sit in a chair or to walk in the last day?
 | ☐ Yes | ☐ I would like to talk to someone about this  | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Are you in pain or discomfort today?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you feel able to get to the bathroom for the toilet or to shower?
 | ☐ Yes | ☐ I would like to talk to someone about this  | ☐ No |
| Comments: |

We understand that you may not be going home today, but I want to ask you a few questions where you should imagine what you might do or feel if you were home and recovering from your illness:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you be able to care for yourself without help from others?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you be able to get your own medications?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you know what problems to watch for?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you know where to call if you had problems?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you be able to do personal care such as bathing, toileting, and eating?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you be able to get support for emotional needs (such as sadness or anxiety)?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you be able to do things like cooking, cleaning, or shopping?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Would you understand the overall plan for your recovery?
 | ☐ Yes | ☐ I would like to talk to someone about this | ☐ No |
| Comments: |

|  |
| --- |
| Additional Comments: |