COVID-19 REHABILITATION PATIENT SUCCESS TOOL

Dear Patient,
To get you home, we need to plan from the beginning. Please fill this information out when you come to the hospital. Review it weekly with your nurse and loved ones to help you get ready to go home.

Pain:
☐ Yes  ☐ no

Please rate your pain

![Wong-Baker FACES™ Pain Rating Scale](image)

Function before illness:
☐ Yes  ☐ no  Working
☐ Yes  ☐ no  Use an assistive device such as a cane or walker
☐ Yes  ☐ no  Need to have someone else help you with basic activities
☐ Yes  ☐ no  Needed to have help with heavy work like yardwork
☐ Yes  ☐ no  Needed to have help with thinking work like paying bills

Right now:
☐ able ☐ need help  ☐ cannot  Eat
☐ able ☐ need help  ☐ cannot  Bathe
☐ able ☐ need help  ☐ cannot  Comb hair, shave, wash
☐ able ☐ need help  ☐ cannot  Put on and take off clothes
☐ able ☐ need help  ☐ cannot  Control my bowels
☐ able ☐ need help  ☐ cannot  Control my bladder
☐ able ☐ need help  ☐ cannot  Use the toilet by myself
☐ able ☐ need help  ☐ cannot  Get into a chair and back
☐ able ☐ need help  ☐ cannot  Walk
☐ able ☐ need help  ☐ cannot  Go up and down stairs

Patient name: _________________________________
Date: ________________________________________
Patient number: _______________________________
Going home:
☐ Yes  ☐ no  I can get in and out of the house
☐ Yes  ☐ no  I can get into the bathroom and bedroom
☐ Yes  ☐ no  I’ll have the food, heat, and water I need
☐ Yes  ☐ no  Someone who is able to help me will be there

Name of Primary Caregiver: ____________________________________

Phone number: ______________________________________________

The week of discharge:
☐ Yes  ☐ no  I have the assistive devices and supplies I need (cane, wheelchair)
☐ Yes  ☐ no  I know the medicines I’ll take when I go home
☐ Yes  ☐ no  My family or support knows how to take care of me
☐ Yes  ☐ no  I’ve been connected to a rehabilitation and exercise plan

When I get home:
☐ Yes  ☐ no  I’ll feel safe at home
☐ Yes  ☐ no  I think I’ll likely fall
☐ Yes  ☐ no  I think I’ll likely fall apart emotionally
☐ Yes  ☐ no  I think my caregivers will likely fall apart emotionally
☐ Yes  ☐ no  I won’t have enough money to survive the next month

Do you have any other concerns that you wish a rehabilitation expert would address?
_________________________________________________________________________________

Please return this form to _____________________

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