Hospital Checklist

Everything a doctor, nurse, or therapist needs to know — gathered before you need it.

When a loved one arrives at the hospital, the care team's main concern is keeping them safe and treating what's medically urgent right now. But alongside that, one of their first jobs is figuring out who this person was *before* they got sick or hurt: what they could do, what medications they take, who to call, and what their wishes are. Family and caregivers are usually the only ones who know that information — and in the middle of an emergency, it's easy to forget details or leave something important unsaid. Filling this out ahead of time (and keeping a copy handy) helps the hospital team give faster, safer, more personalized care from the moment your loved one arrives. For a deeper look at navigating a hospital stay, see Chapter 7 (“Navigating Medical Settings”) and Chapter 8 (“Insurance and Care Coverage”) of Stephen Stashevsky's book, *Caring for Your Aging Loved One* (advocatesonaging.com/book.html).

When to Use This

Fill this out ahead of a planned hospital stay (surgery, a scheduled procedure) so it's ready to hand to admissions. Just as important: fill it out now, before you need it for an unplanned ER visit. Keep one printed copy in an easy-to-grab spot by the door, one in your loved one's overnight bag, and a photo of it on your phone. Update it whenever a medication, physician, or care need changes.

Patient & Emergency Contact Information

Patient full name:

Date of birth:

Weight (helps with medication dosing):

Phone number:

Home address:

Primary caregiver name:

Primary caregiver phone:

Emergency contact #2 (name & relationship):

Emergency contact #2 phone:

Physicians & Care Team

Role / Specialty	Name	Phone Number	Practice / Clinic

Preferred pharmacy: _____ **Pharmacy phone:** _____

Home health agency (if any): _____ **Home health agency phone:** _____

Insurance & Legal Documents

Primary insurance / Medicare #: _____ **Secondary insurance #:** _____

Healthcare Power of Attorney (name): _____ **POA phone number:** _____

- ☐ Advance directive / living will is on file with this hospital or attached to this sheet
- ☐ POLST (Physician Orders for Life-Sustaining Treatment) is on file, if applicable
- ☐ DNR (Do Not Resuscitate) status has been discussed and documented, if applicable
- ☐ A copy of insurance cards (front and back) is attached or ready to bring

Medical History

Diagnoses & chronic conditions

Check any that apply, then use the space below for anything not listed, plus dates, stages, or details the care team should know.

HEART & CIRCULATION

- ☐ High blood pressure
- ☐ Heart failure (CHF)
- ☐ Coronary artery disease
- ☐ Atrial fibrillation
- ☐ Prior heart attack
- ☐ High cholesterol
- ☐ Blood clot (DVT or PE)
- ☐ Peripheral vascular disease

ENDOCRINE & KIDNEY

- ☐ Diabetes (type 1 or 2)
- ☐ Thyroid disease
- ☐ Chronic kidney disease
- ☐ On dialysis
- ☐ Osteoporosis

OTHER

- ☐ Cancer (current or past)
- ☐ GERD / reflux
- ☐ Liver disease
- ☐ Anemia
- ☐ Incontinence
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Weakened immune system

BRAIN & NERVES

- ☐ Stroke or TIA
- ☐ Dementia or Alzheimer's
- ☐ Parkinson's disease
- ☐ Seizure disorder
- ☐ Neuropathy
- ☐ Depression or anxiety
- ☐ History of delirium

LUNGS

- ☐ COPD or emphysema
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Uses home oxygen

BONES & JOINTS

- ☐ Arthritis (OA or RA)
- ☐ Prior hip or knee replacement
- ☐ Prior fracture
- ☐ Chronic back or neck pain

Other conditions, and any detail on the above (dates, stage, severity, which side):

Past surgeries (procedure & approx. date):

Allergies (medication, food, latex, other) and the reaction they cause:

Current Medications

List every medication, including over-the-counter drugs, vitamins, and supplements. If it's easier, attach a pharmacy printout or bring the actual pill bottles instead of filling this in by hand — either works, as long as it's current.

Medication	Dose	Frequency	Prescribing Doctor

Prior Level of Function (PLOF)

This section is one of the most valuable things you can hand a clinical team. It tells them what “back to normal” looks like for your loved one, which shapes everything from fall-risk precautions to discharge planning.

Mobility & Transfers

DEVICE USED

- ☐ None — walked independently
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Scooter
- ☐ Other: _____

LEVEL OF ASSISTANCE NEEDED

- ☐ Independent / stand-by supervision only (no hands-on help)
- ☐ Partial assist (some hands-on help)
- ☐ Moderate assist (significant hands-on help)
- ☐ Heavy assist (unable to walk or transfer without substantial help)

STAIRS & FALLS

- ☐ Could climb stairs independently | needed a rail | unable to climb stairs (circle one)
- ☐ Had any falls in the past 6 months? If yes, describe below

Details / describe assistance needed:

Daily Activities (ADLs / IADLs)

For each activity, check the column that best describes the level of help needed before this hospital stay.

	Independent	Reminders Needed	Partial Assist	Moderate Assist	Heavy Assist
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Meal prep / cooking	☐	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐	☐
Managing medications	☐	☐	☐	☐	☐
Managing finances	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐

Details / describe assistance needed:

Cognitive & Communication Baseline

- ☐ Alert and oriented to person, place, and time at baseline
- ☐ Has a pattern of being drowsier at certain times, or “sundowning” (increased confusion later in the day)
  Example from the book: “Fully alert. Drowsy in the morning. Little sundowning starting at 4pm.” Noting this baseline helps staff tell what's normal from what's new.
- ☐ Diagnosed with dementia or memory impairment (note stage/type below, if known)
- ☐ Primary language, and whether an interpreter is typically needed
- ☐ Uses hearing aids, glasses, or dentures — bring these to the hospital

Details (dementia stage, language, communication needs):

Home Environment

Lives alone? (Y/N):

Who else lives in the home:

Stairs to bedroom/bathroom? (Y/N):

Caregiver availability (hours/days):

Durable medical equipment currently used (walker, wheelchair, hospital bed, oxygen, etc.):

Additional services in place (Meals on Wheels, paid caregiving hours/week, home health, etc.):

Helping prevent hospital-acquired delirium

Unfamiliar environments, disrupted sleep, and illness can cause a distressing decline in an older adult's thinking during a hospital stay — increased confusion, agitation, or withdrawal. Bringing glasses, hearing aids, and familiar items from home, and keeping a semi-normal day/night routine, can help reduce the risk. Many people improve over the weeks after discharge, but recovery is often slower than families expect and can take months; for some, thinking does not return fully to baseline. Tell the care team if confusion is new, and tell the physician again if it hasn't cleared once your loved one is home. See Chapter 7 of the book for more.

What to Bring to the Hospital

- ☐ Photo ID and insurance cards
- ☐ This completed checklist, or a current medication list / pill bottles
- ☐ Copy of advance directive, POLST, or healthcare POA paperwork
- ☐ Glasses, hearing aids (with case and charger/batteries), and dentures
- ☐ Phone and charger
- ☐ Comfortable clothing, a robe, and non-skid socks
- ☐ Basic toiletries
- ☐ A short list of physicians and their phone numbers (see above)
- ☐ A small amount of cash for vending machines, parking, etc.

Questions to Ask Before Discharge

Discharge day moves fast — doctors are rounding, nurses are preparing paperwork, and it's easy to absorb only part of what's said. These questions are drawn from Chapter 7 of the book, which walks through exactly this transition:

- ☐ Was my loved one admitted as an inpatient, or kept under observation status?
  This distinction matters. Under Original Medicare, a qualifying inpatient stay of three consecutive midnights is generally required before a follow-up skilled nursing facility stay is covered. Time spent under observation does not count toward it, even if your loved one was in a hospital bed overnight. Medicare Advantage plans set their own rules and often waive this requirement — ask the case manager which applies to your plan.
- ☐ Can we speak with a social worker or case manager before discharge?
  They can explain insurance coverage, help arrange rehab placement, coordinate home health, and connect you with community resources.
- ☐ What is the diagnosis, and what does a typical recovery course look like?
- ☐ What medications have changed — what's new, what's stopped, and why?

Related resources

Pair this with the **Coming Home Checklist** to get the house ready before discharge, and the **Home Safety Checklist** to re-evaluate the home if mobility looks different afterward. Both are part of the Home Health Essentials bundle in the Member Library at advocatesonaging.com/member-library.html. Our **Recommended Equipment guide** at advocatesonaging.com/equipment.html is free to everyone, no account needed.