Name (preferred): _____ **Nurse:** _____ **Today's Date:** _____

Family Contact: _____ **Clinical Partner:** _____ **Day of Week:** _____

Physician: _____ **Charge Nurse/CN4:** _____ **Room # :** _____

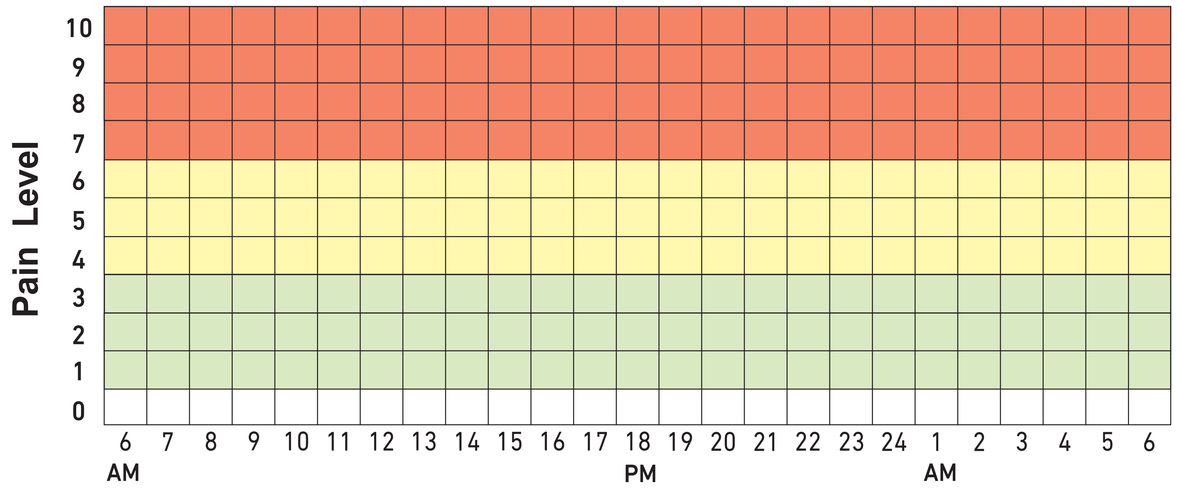
Nurse Manager: _____ **Room Phone # :** _____

Hourly Rounding

Time AM ☐ PM ☐	7	8	9	10	11	12	1	2	3	4	5	6
Nurse / CP												

Patient Preferences

PAIN MANAGEMENT



	Medications	Next Dose
Scheduled Medications		
Severe		
Moderate		
Mild		

What Works for Me

☐ _____

☐ _____

☐ _____

MY ROAD TO WELLNESS

Before I leave the hospital, I need to know the following:

- What to eat
- How much activity to do
- What medicine to take & when
- What signs/symptoms to watch for
- When to see my doctors
- Why I am in the hospital

If I have any questions, I should ask my doctor or nurse before I leave the hospital.

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PLAN FOR THE DAY / DISCHARGE PLAN

Anticipated Discharge Date: _____