**Transition of Care Coordination Plan**

Attention: _____ Date: _____

Re: _____ DOB: _____

_____, presently admitted to your facility, has been an active patient of the Visiting Nurse Association since _____. This patient has been identified at high risk for hospitalization and a comprehensive assessment and collaborative discharge plan is indicated to assure a safe transition to the appropriate level of care, keeping in mind the patient's wishes

The following high risk factors have been identified and need to be addressed prior to patient's discharge.

- ❑ Multiple diagnosis and co-morbidities
- ❑ Impaired mobility
- ❑ Impaired self care skills
- ❑ Poor cognitive status
- ❑ Patient requires 24 hour care and medical needs can not be managed safely at home
- ❑ Home environment inhibits the provision of care
- ❑ No willing and/or able caregiver
- ❑ Chronic illness
- ❑ Anticipated long term health care needs
- ❑ Substance abuse
- ❑ History of multiple hospital admissions
- ❑ History of multiple emergent care use
- ❑ Unsafe living alone
- ❑ Patient and/or family are not willing to comply with the physician's plan of treatment
- ❑ Patient does not have a primary care physician
- ❑ Other: _____

The Visiting Nurse Association is recommending the following interventions be initiated to transition the patient to the appropriate level of care.

_____
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_____

_____ ,from the Visiting Nurse Association, will be contacting you to discuss the recommended plan and assist in the patient's transition from your facility.

Signature Date