

**COVID -19 REHABILITATION PATIENT SUCCESS TOOL**

Patient name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Patient number: \_\_\_\_\_

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**



**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:**

(Barthel Index)

- |                               |                                    |                                 |                             |
|-------------------------------|------------------------------------|---------------------------------|-----------------------------|
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Eat                         |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Bathe                       |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Comb hair, shave, wash      |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Put on and take off clothes |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Control my bowels           |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Control my bladder          |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Use the toilet by myself    |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Get into a chair and back   |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Walk                        |
| <input type="checkbox"/> able | <input type="checkbox"/> need help | <input type="checkbox"/> cannot | Go up and down stairs       |

**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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