The Joint Surgery Center
DISCHARGE PLANNING

In our efforts to look beyond your surgery to your discharge from the hospital, please answer the questions below, and return this form to us at the end of class. Your team will plan for the best – healthiest and safest – option for you.

Thank you!

Name:_____**Date of Surgery**:_____
Address:_____
City/State/Zip:_____
County: _____
Your phone number: H:_____Cell:_____
If you are recovering at somebody else's home, please provide the address:
_____

Coach/Caretaker Name _____Relationship: _____
Contact number: home/cell: _____

Have you used a VNA (visiting nurse association) before? □ Yes □No
If yes, do you want to use the same VNA after this surgery? □ Yes □No
Name of VNA :_____

Primary Insurance Coverage (pick one):
□ Traditional Medicare □Managed Medicare _____
□ Private_____ □ Medicaid_____
□Work Comp_____ If Workers Comp, Claim#_____
If Worker's Comp, Claims adjuster (name/number) _____
Secondary Insurance Coverage (pick one):
□ Traditional Medicare □Managed Medicare_____
□ Private_____ □ Medicaid_____

Discharge Plan
Home Equipment: Do you have?
Walker Yes ☐ No ☐
Commode Yes ☐ No☐
Cane Yes ☐ No ☐

Any additional comments?_____