Transitional Care Agreement

Patient

As the patient, I understand that it is my responsibility to follow the instructions provided to me today in addition to the Recovery Plan my doctor prepared for me. If at any time I cannot follow the instructions I will tell my caretaker(s) and/or my doctor so they can ensure I receive the help I need. I am being provided with the contact information for all the healthcare professionals on my support team and will save this sheet so I know who I can call for help with my health.

Patient Name (Please Print)

Patient Signature

Date

Caretaker(s)

As the caretaker(s) of the patient, I understand that it is my responsibility to ensure the patient is fully supported during their recovery from their hospitalization. If at any time I cannot fully support the patient, or have identified something that will prevent the patient from receiving care, I will contact their doctor immediately.

Provider/Doctor

As the patient's doctor, I understand that it is my responsibility to ensure the patient understands what is expected of them during their recovery, and ensure they are fully supported during this time. I will prepare a Recovery Plan for the patient based on our meeting today and communicate this Recovery Plan to patient and their caretaker(s) and ensure the information is fully understood. I will maintain communication with the patient and caretakers for no less than 30 days post-discharge.

Provider/Doctor Name (Please Print)

Provider/Doctor Signature

Date