EvergreenHealth Monroe

14701 179th Ave SE
PO Box 646
Monroe WA 98272

TOTAL JOINT REPLACEMENT PRE-SURGERY SCREENING

Date:_____

Patient Name:_____Date of Birth:_____

Date of Surgery:_____
Type of Surgery:_____Right Hip _____Left Hip _____Right Knee _____Left Knee

Primary Insurance:_____

Secondary Insurance:_____

Patient lives at:
_____Home _____Mobile Home _____RV _____Adult Family Home _____Homeless

_____Retirement Community _____Assisted Living

_____Other, Please Explain:_____

How many stories is your home?_____How many steps to enter your home?_____
How many steps to get to your main living area?_____

Do you have pets in the home? If so, please explain:
_____
_____

Physical address of where you will be staying upon discharge:
_____
_____

You will need a caregiver to stay with you for the first full week, 24 hours a day. Please list the name(s) and phone number(s) of your caregiver(s):

Name:_____Relationship:_____
Phone#:_____
Name:_____Relationship:_____
Phone#:_____
Name:_____Relationship:_____
Phone#:_____

Home Health is highly recommended for patients who are discharged to home. Please mark your preference for a Home Health Agency:

_____Evergreen Home Health _____Providence Home Health _____Gentiva Home Health

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If you need to go to a Skilled Nursing Facility for Rehabilitation, please list your top 3 choices for agencies:

1. _____
2. _____
3. _____

Please mark the following Durable Medical Equipment that you currently have access to:

_____Wheelchair	_____Front Wheeled Walker	_____Cane
_____Commode	_____Raised Toilet Seat	_____Crutches
_____Shower Chair	_____Shower Grab Bars	_____Crutches
_____Hand Held Shower Head	_____Other_____	

Are you on Home Oxygen? _____Yes _____No

Who will provide transportation for you when you are ready to be discharged from the hospital?

Name:_____Relationship:_____
Phone#:_____
Name:_____Relationship:_____
Phone#:_____

Please provide the name of your Primary Care Physician:

Name:_____Medical Center:_____
Phone#:_____

Do you have an Advanced Directive? _____Yes _____No If yes, please provide a copy to the hospital admitting office.

Discharge Planning Notes:

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