

30-Day Recovery Planner

Your first month home: appointments, therapy, equipment, and help, week by week.

NAME / PERSON THIS SHEET IS FOR

DISCHARGE DATE

REASON FOR HOSPITAL STAY

MY RECOVERY GOAL BY DAY 30 (FOR EXAMPLE: WALK TO THE MAILBOX, DRIVE AGAIN, SHOWER ON MY OWN)

1 Week-by-week plan

Week 1 is the riskiest. Use the SynquUp™ 7-Day Post-Discharge Planner for day-by-day check-ins that first week.

Week	Appointments and tests	Therapy and exercises	My goal this week	How it went / what changed
Week 1 Days 1–7				
Week 2 Days 8–14				
Week 3 Days 15–21				
Week 4 Days 22–30				

2 Appointments and tests this month

Who or what (doctor, lab, scan)	Date and time	Ride arranged (who)	Questions to bring	Done

☐ My first visit after discharge is booked with a date and time, ideally within 2 weeks.¹

☐ At that first visit, I asked my primary care provider to review **all** my medicines.²

☐ Every specialist on my discharge papers has a booked visit, not just a referral.⁷

☐ I brought the SynquUp™ Doctor Appointment Prep Sheet to each visit.

TRU-TIP • Ask for transitional care by name

If you have Medicare and had an inpatient stay, Part B covers transitional care management. A provider works with you for the first 30 days home, with a visit within 2 weeks.¹ Coinsurance may apply. Call your primary care office and ask: “Do you offer transitional care management, and can I be scheduled for it?”

3 Therapy, home health, and equipment

Service or equipment (PT, OT, home health nurse, walker, oxygen...)	Company or therapist	Phone	Schedule / visits	Working?

Medicare home health: you may qualify if you are homebound and need part-time skilled care, ordered by your provider after an in-person visit. A hospital stay is not one of the listed requirements.³

Warning signs, help, and how I am doing

4 Warning signs: my plan

Warning sign from my discharge papers or care team	What I do	Who I call / phone

- ☐ I tell my care team about any fall, even if I was not hurt.⁴
☐ I tell my care team if I am more confused, more tired, or eating and drinking less than before.
- ☐ If my mood is low or I feel hopeless, I tell someone. In a crisis, I call or text 988.⁹

CALL 911 RIGHT AWAY

For chest pain, trouble breathing, fainting, or signs of stroke: face drooping, arm weakness, slurred or strange speech, sudden loss of balance or vision.⁵

5 Community help: call before you need it

Resource	Who I talked to and date	Reference # / what happens next
Area Agency on Aging Eldercare Locator: 1-800-677-1116 · eldercare.acl.gov		
211 helpline Dial 211: food, bills, housing, caregiver help		
Home-delivered meals Meals on Wheels or my Area Agency on Aging		
Rides to medical visits Medicaid NEMT, my health plan, or local programs		
PACE Age 55+, some areas, nursing-home level of need		

TRU-TIP • Call before you need it

Meals, rides, and in-home help often have intake calls, assessments, or waitlists. If you wait until you are in trouble, help may be weeks away. Call in Week 1, even if you think you will not need it, and write down who you spoke with, the date, and any reference number.⁶

TRU-TIP • Test equipment the day it arrives

Do not wait until 2 a.m. to learn the oxygen tubing is the wrong length or the walker is set too low. Have the delivery person show you how it works, try it while they are there, and keep the company's 24-hour number on the device.⁷

6 Day 30 check-in

- ☐ All my medicines were reviewed, and my list is updated.²
☐ If I have Medicare drug coverage, I asked about a free Medication Therapy Management review.⁸

WHERE I AM COMPARED WITH MY GOAL, AND WHAT I STILL NEED HELP WITH

Want to go further? The SynquUp™ Emergency Life Binder recovery pages and Aging Alone by Chuck Kinney help you build a support system that is ready before the next hospital stay. Free tools: chuckkinney.com/free