FAMILY TOOL

Hospital/Rehab Return Medication Checklist

Use these questions after a return to clarify what changed and whether the current facility medication process matches the authorized discharge and provider instructions. Do not change or stop a medication on your own.

HOW TO USE	Mark each item Yes, No, Not Applicable, or Needs Follow-up in your working copy. Add evidence, an owner, and a recheck for every gap. Do not use this public blank template to transmit resident information.

Before or at return

- [ ] Ask for the current discharge medication list and instructions through authorized channels.
- [ ] Ask which medications are new, changed, stopped, held, or resumed.
- [ ] Ask when each change is intended to begin and who is responsible for entering and verifying it.
- [ ] Ask whether any medication must be obtained before the next scheduled dose.
- [ ] Ask whether diet, wound, follow-up, monitoring, mobility, or treatment instructions also changed.

Compare the sources

- [ ] Does the discharge list match the facility's current medication record?
- [ ] Are discontinued medications clearly removed from the active process?
- [ ] Do dose, route, timing, and special instructions agree?
- [ ] Are held, refused, unavailable, or delayed medications visible to the nurse responsible for follow-up?
- [ ] Is available pharmacy information consistent with the current authorized order?
- [ ] Are allergies and relevant restrictions current in the sources staff use?

First days after return

- [ ] Ask who is watching for a change in alertness, dizziness, blood pressure concerns, intake, mobility, falls, behavior, or other ordered monitoring.
- [ ] Ask what follow-up appointments, tests, labs, or provider calls remain open.
- [ ] Ask how open items will be carried across shifts until completed.
- [ ] Confirm the family knows whom to contact at the facility with a concern.
- [ ] Write down questions for the treating provider rather than changing the treatment plan independently.

If something does not match

- [ ] Describe the discrepancy without including private details in an unsecured message.
- [ ] Contact an appropriate facility clinician and the treating provider as clinically appropriate.
- [ ] Ask who owns resolution and when the family will receive confirmation.
- [ ] Use emergency services when the resident's condition requires emergency care.

Working notes

Use a secure facility or family working copy when recording any resident-specific details. Keep the public blank tool free of identifying information.

Return date	_____
Discharge source reviewed	_____
Facility source reviewed	_____
Medication change questions	_____
Other changed orders	_____
Open follow-up	_____
Person responsible for confirmation	_____

Action and verification log

Action / control	Owner	Due	Evidence / result

Scope disclaimer

This tool is a general process-control aid. It does not replace emergency care, treating-clinician judgment, legal advice, or facility-specific regulatory review. It does not establish a treating relationship or guarantee compliance or outcomes. Use authorized secure methods for resident-identifying information and records.

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