**Section 2: Logistics and Hard Exclusion Criteria**

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| --- | --- | --- | --- | --- |
| **1** | Do you have plans to move in the next 5 days? | | *yes*   | *no*   |
| **2** | Do you have plans to move to a Skilled Nursing Facility or Nursing Home in the next 30 days? | | *yes*   | *no*   |
| **3** | Are you planning to travel in the next 5 days? | | *yes*   | *no*   |
| **4a** | Are you planning to travel in the next 30 days? | | *yes*   | *no*   |
| **4b** | If traveling in the next 30 days, will you be able to accept follow up phone calls from your Recovery Care Coordinator? | | *yes*   | *no*   |
| **5** | Please describe where you live:   * Apartment * Assisted Living Facility * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |
| **5b** | Are there any special instructions for getting into your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |
| **6** | Do you use any durable medical equipment to help you in your home?  **❑** Wheelchair  **❑** Cane  **❑** Specialty Bed  **❑** Wheeled Walker  **❑** Crutches | **❑** Transfer Bench  **❑** Bedside Commode  **❑** Bath Seat  **❑** BiPAP/CPAP  **❑** Oxygen  **❑** Nebulizers  **❑** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **7** | Do you or anyone in your home use or is involved in the selling of recreational/illicit drugs? | | *yes*   | *no*   |
|  | Are you comfortable with health care professionals making multiple daily visits to your home? This includes but is not limited to nurses, x-ray technicians, or EMTs. | | *yes* | *no* |
| **8** |  |  |
| **9** | If other people live in your home, are they comfortable with health care professionals making multiple daily visits to your home? | | *yes*   | *no*   |
| **10** | Do you have a working home telephone or mobile phone available 24/7 with which you could call the Hospital at Home team in case of an emergency? | | *yes*   | *no*   |
| **11** | Does your home have:   * Electricity * Running water * Access to refrigeration | | *yes*   | *no*   |
| **12** | Do you have any firearms in your home? | | *yes*   | *no*   |
| **12b** | If you have firearms in the home, are you able to store them unloaded and in a locked case for the duration of your Hospitalization at Home admission? | | *yes*   | *no*   |
| **13** | Do you have any pets that move freely about your home (e.g. dogs, cats, birds, reptiles)? | | *yes*   | *no*   |
| **13b** | If yes, can the pet be placed in another room or a crate during visits by health care workers? | | *yes*   | *no*   |
| **14** | Do you currently have bed bugs (confirmed or suspected)? | | *yes*   | *no*   |
| *HaH Staff Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | |