



My Care Coordination Journey





We are ready to help you get back to what matters!

Welcome to Larksfeld Place Health Care & Rehabilitation where your very-own team is prepared to advance your journey to maximized independence.

You are about to experience a 5-star quality rated community and a rehab team lead by a nationally recognized director. For over twenty-eight years, Larksfeld has built a deserved reputation as the Wichita leader by putting our focus on quality, care and service. All of our care services are provided by Larksfeld employees, not by contracted caregivers whose interests will not be as committed as ours.

Rehabilitation is a time-limited, goal-orientated process where your goals are conveyed between you, your loved ones and your care team. Communication with your primary doctor is of the highest importance to us and a review of your progress towards your goals is completed with you on a regular basis.

Our team is enthusiastic to help you understand and navigate your way through the rehabilitation process and explain to you and your loved ones some of the things that may happen during your stay.

It's All about Me! Section A

- 😊 I prefer to be called: _____
- 😊 I prefer to get up at: _____
- 😊 I prefer to go to bed at: _____
- 😊 I would like showers or baths: _____
- 😊 I prefer my showers/baths during the a.m. or p.m. _____
- 😊 I prefer my showers/bath days to be: _____
- 😊 For fun I like to: _____
- 😊 Pets: _____
- 😊 Lifetime Accomplishments: _____
- 😊 _____
- 😊 Favorite foods: _____
- 😊 Other: _____
- 😊 _____

1st Day of my Journey

Date: _____

- 😊 Height: _____
- 😊 Weight: _____
- 😊 Admission Vital Signs: _____

😊 Aids/Mobility devices I brought with me:

- Glasses
- Hearing Aids
- Dentures
- Walker
- Wheelchair
- Cane
- Other _____

My Preferences
Section B

😊 I currently live/with: _____
😊 _____

😊 I plan to discharge to: _____
😊 _____

😊 3 of my strengths are:
😊 _____
😊 _____
😊 _____

😊 3 of my weaknesses are:
😊 _____
😊 _____
😊 _____

😊 What motivates me? _____
😊 _____

😊 What discourages me? _____
😊 _____
😊 _____

😊 I learn best by: _____
😊 _____

😊 I prefer my therapy (specify time): _____

😊 I typically take my afternoon/evening medications at (specify time):
😊 _____

😊 I typically take my bedtime medications at (specify time): _____
😊 _____

**My Demographics
Section C**

☺ Date of Birth _____ Place: _____

☺ Language Spoken: _____

☺ Religion / Church Affiliation: _____

☺ Religion Contact: _____

☺ Education: _____

☺ Work History: _____

☺ History of Alcohol/Drug Misuse/Smoking _____

☺ _____

☺ Coping Skills Used in the past: _____

☺ _____

☺ Ability to Understand/Be understood: _____

☺ _____

☺ Hearing/Vision: _____

☺ _____

☺ Marital History (List spouse, significant others, children and the quality of these relationships)

☺ _____

☺ Childhood (include parents, siblings and quality of relationships)

☺ _____

☺ Additional Information: (i.e. leisure activity, other comments by client)

**Client Home History
Section D**

Prior to my hospitalization, some difficulties in my current setting were?

Based on my initial home review, the team feels when I return home I may need additional help with the following items:

 _____

 _____

 _____

 _____

 _____

 _____

My Mobility Goals before I Leave Section E

😊 I will complete a home evaluation with my therapy team on

😊 I will be able to move from sitting on the bed to lying flat independently.

😊 I will be able to safely move from lying on my back to sitting on the side of the bed independently.

😊 I will be able to safely come to a standing position from my bed or chair independently.

😊 I will be able to safely get on and off the toilet independently.

😊 I will be able to safely walk _____ feet with two turns independently.

😊 I will be able to safely walk _____ feet in a corridor or similar space independently.

😊 _____

😊 _____

My Self-Care Goals before I Leave
Section F

😊 I will be able to use suitable utensils to bring food to my mouth and swallow with no difficulties independently.

😊 I will be able to independently take care of my oral hygiene.

😊 I will be able to maintain perineal hygiene, adjust clothes before and after using the toilet independently.

😊 _____

😊 _____



Name: _____

My Education Goals before I Leave
Section G











Name: _____

<p style="text-align: center;">My Follow-Up Needs Section H</p>

😊 I follow up with my PCP on _____.
The contact number is _____.

😊 My wheelchair and walker will be provided by _____.
They will be delivered on _____.

😊 I will be using _____ Home Health.
Their contact number is _____.

😊 I will be using _____ Pharmacy.
Their contact number is _____.