



First 30 Days: Exact Tasks for Caregivers

Use this as an action list, not a test. Every open task should have a named owner and a next date. Follow the treating team's instructions for medical decisions and emergencies.

DAY 0 - Before leaving the hospital

Complete what applies before you walk out the door.

TASK	OWNER / BY
☐ Put the discharge instructions, current medication list, referral orders, and follow-up instructions into one folder or envelope before leaving.	_____
☐ Highlight the exact section of the discharge instructions that says when to call the treating team, when to use an after-hours number, and when to seek emergency care.	_____
☐ Save the hospital unit or discharge contact, primary follow-up office, pharmacy, and after-hours number in your phone with clear labels.	_____
☐ For every medication listed at discharge, write the medication name, dose, time of day, reason it is being taken on the medication list sheet, and whether anything was stopped or changed.	_____
☐ For every recommended follow-up, write the provider/specialty, why the visit is needed, the recommended time frame, who sends the referral, and who is expected to schedule it.	_____
☐ Ask: "If this referral or appointment does not happen, who do I call?" Write down the name and number you are given.	_____
☐ Ask how to obtain the discharge summary, imaging reports, and visit records through the portal or medical-records department, and write down the instructions.	_____

FIRST 24 HOURS HOME

Create one system before paperwork, calls, and observations start multiplying.

TASK	OWNER / BY
☐ Fill every discharge prescription and compare the pharmacy label against the written discharge medication list; write down any mismatch to clarify with the prescribing team or pharmacist.	_____
☐ Create one medication schedule showing the exact times medications are due; place it where the caregiver actually gives or checks medications – recommended to set alarms on your phone.	_____
☐ Create one master contact list with primary care, hospital/discharge contact, specialists, pharmacy, insurance, case manager/patient advocate if any, and one family backup person.	_____
☐ Enter every known appointment into one calendar with provider name, address or telehealth link, reason for visit, arrival time, and anything you were told to bring.	_____
☐ Start a daily caregiver note with the provided caregiver sheet.	_____
☐ Designate one person to update extended family and friends so the primary caregiver is not repeating the same status update all day.	_____

TASK	OWNER / BY
☐ Set a visitor rule for the first week: who may come, how long visits last, and who can say “not today” without needing to explain.	_____

DAYS 2–7

Close the loops created by discharge.

TASK	OWNER / BY
☐ Call every office named in the discharge plan that has not already scheduled the survivor; record the date called, person spoken with, and next promised step. Set reminder in phone for follow up in two weeks, if you haven’t heard back.	_____
☐ For each referral, confirm that the receiving office actually has the referral and any records it requires; do not assume “sent” means “received.”	_____
☐ Call the insurance plan about each recommended service that may require authorization; record the representative name, reference number, and what the office says is still needed.	_____
☐ Prepare a one-page “before injury / now” note with concrete examples of changes in memory, attention, stamina, sleep, sensory tolerance, mood, mobility, communication, or daily routines that the family is actually seeing.	_____
☐ Before the first follow-up visit, write the three questions you most need answered and bring the medication list, symptom/caregiver notes, and discharge paperwork.	_____
☐ After every appointment, add the visit summary to the folder, write the next action in plain language, name who owns it, and put the follow-up date on the calendar.	_____

WEEK 2 • Reconcile what is actually happening

Use the second week to find missing handoffs and turn observations into usable information.

TASK	OWNER / BY
☐ Compare the written medication list with what is actually being taken at home; mark new medications, stopped medications, missed doses, and any questions to take to the prescribing clinician or pharmacist.	_____
☐ Review every referral and authorization from week one. For anything still pending, call again and write the new status and next check-in date.	_____
☐ Read the first week of caregiver/symptom notes and circle repeated patterns: time of day, activity, environment, recovery time, or situations that repeatedly make functioning harder.	_____
☐ Turn vague descriptions into three concrete examples for the next appointment, such as what the survivor tried to do, what changed, how long it lasted, and what happened afterward.	_____
☐ If work or school is involved, ask the treating provider what restrictions or accommodations should be documented in writing; send only the necessary written information to the employer or school.	_____
☐ Assign at least one recurring caregiver task to another named person - transportation, meals, pharmacy pickup, family updates, paperwork scanning, or sitting with the survivor during an appointment.	_____

WEEKS 3–4 · Build the 30-day picture

By the end of the month, the goal is a usable snapshot of what changed and what still needs action.

TASK	OWNER / BY
☐ Fill out 30-day summary with four headings: improved, unchanged, worse, and new. Put specific functional examples under each heading.	_____
☐ Make a single list of all appointments completed, appointments scheduled, referrals still pending, and questions that no provider has answered yet.	_____
☐ Ask the current lead provider which unresolved issue belongs to which provider or specialty; write the name of the person or office expected to handle each one.	_____
☐ Organize insurance letters, authorizations, denials, bills, receipts, mileage, and claim/reference numbers into one paper or digital folder by date.	_____
☐ Review the calendar for the next 30 days and add transportation, paperwork, medication-refill, work/school, and caregiver-coverage needs before they become same-day problems.	_____
☐ Schedule a 15-minute family reset: decide which three issues matter most next month, who owns each one, and what can wait.	_____

AT EVERY APPOINTMENT

Use the same routine so important details do not disappear between offices.

TASK	OWNER / BY
☐ Bring the current medication list, the one-page change summary, the three most important questions, and one or two concrete examples from home.	_____
☐ Write the provider's answer in plain language while you are in the room, or request to record a voice note; do not rely on remembering it later.	_____
☐ Before leaving, ask: "What is the next step? Who is doing it? By when? What should I do if it does not happen?"	_____
☐ Confirm whether the office is sending referrals/records or whether the family must call; write the destination and contact information.	_____
☐ Schedule the next visit before leaving when possible, or put a specific date on the calendar to call and schedule it.	_____
☐ Save the after-visit summary the same day and update the master action list before the paperwork goes into the folder.	_____

Caregiver rule: every open task gets an owner, a next step, and a date to check it again.