

## AFTER HOURS COVERAGE/EMERGENCY PLAN

We have a nurse on call 24 hours a day, 7 days a week to ensure that you receive necessary home care services. We do not carry medications with us and cannot give anything unless ordered by the physician. After office hours and on weekends, an answering service will reach the nurse and he/she will return your call, answer any questions you may have, or come to see you if necessary.

**Please call the nurse at \_\_\_\_\_ if you experience any of the items checked (associated with your current condition) or if you develop any other problems (unchecked) as follows:**

<input type="checkbox"/> <b>Heart/Lung Problems:</b> <ul style="list-style-type: none"> <li>• New onset of a productive/frothy cough or new congestion</li> <li>• Change in color, thickness, odor of sputum</li> <li>• Increased shortness of breath</li> <li>• New onset of irregular or rapid heartbeat</li> <li>• Chest pain relieved by rest or medication</li> <li>• More swelling in your legs or feet</li> <li>• Weight gain of ____ pounds in 24 hours</li> <li>• _____</li> </ul>	<input type="checkbox"/> <b>Too Much Blood Thinner:</b> <ul style="list-style-type: none"> <li>• Bleeding from the nose, mouth, gums, rectum, surgical site</li> <li>• Bruising</li> <li>• Leg pain</li> <li>• Black tarry stools</li> <li>• Blood in urine</li> <li>• _____</li> </ul>
<input checked="" type="checkbox"/> <b>Signs of Infection:</b> <ul style="list-style-type: none"> <li>• Increased redness</li> <li>• Wound gets bigger or more painful</li> <li>• Temperature of 100° F or more</li> <li>• Change in amount, color or odor of wound drainage</li> <li>• _____</li> <li>• _____</li> </ul>	<input checked="" type="checkbox"/> <b>Urinary Problems:</b> <ul style="list-style-type: none"> <li>• Foul odor to urine</li> <li>• Catheter not draining</li> <li>• Low back or flank pain; body aches</li> <li>• Unable to urinate; frequency of urination</li> <li>• Increased weakness</li> <li>• Bloody, cloudy or change in urine color</li> <li>• _____</li> </ul>
<input type="checkbox"/> <b>Diabetic Problems:</b> <ul style="list-style-type: none"> <li>• Sudden weakness</li> <li>• Uncontrollable thirst or hunger</li> <li>• Increased urination</li> <li>• Sweating spells</li> <li>• Sudden dizziness</li> <li>• Frequent headaches</li> <li>• Itching</li> <li>• Drowsiness</li> <li>• Blood sugar level greater than ____ or less than ____</li> <li>• _____</li> </ul>	<input checked="" type="checkbox"/> <b>Other Problems:</b> <ul style="list-style-type: none"> <li>• No bowel movement in 3 days</li> <li>• New skin problems</li> <li>• Change in balance, coordination, strength</li> <li>• Fall with small or no injury</li> <li>• Change in mental status</li> <li>• Signs of high blood pressure or stroke: new onset of headache, dizziness, nosebleeds, blurred vision, ringing in ears, heart palpitations (fluttering)</li> <li>• _____</li> </ul>

### Call 911 if you experience any of the following:

- **A fall with a broken bone or bleeding**
- **Unable to wake patient**
- **Chest pain that medicine doesn't help**
- **Severe or prolonged bleeding**
- **Difficulty in breathing**
- **Severe or prolonged pain**

This information was developed in part by The Carolinas Center for Medical Excellence under a contract with the Centers for Medicare and Medicaid Services (CMS). The contents do not necessarily represent CMS policy.