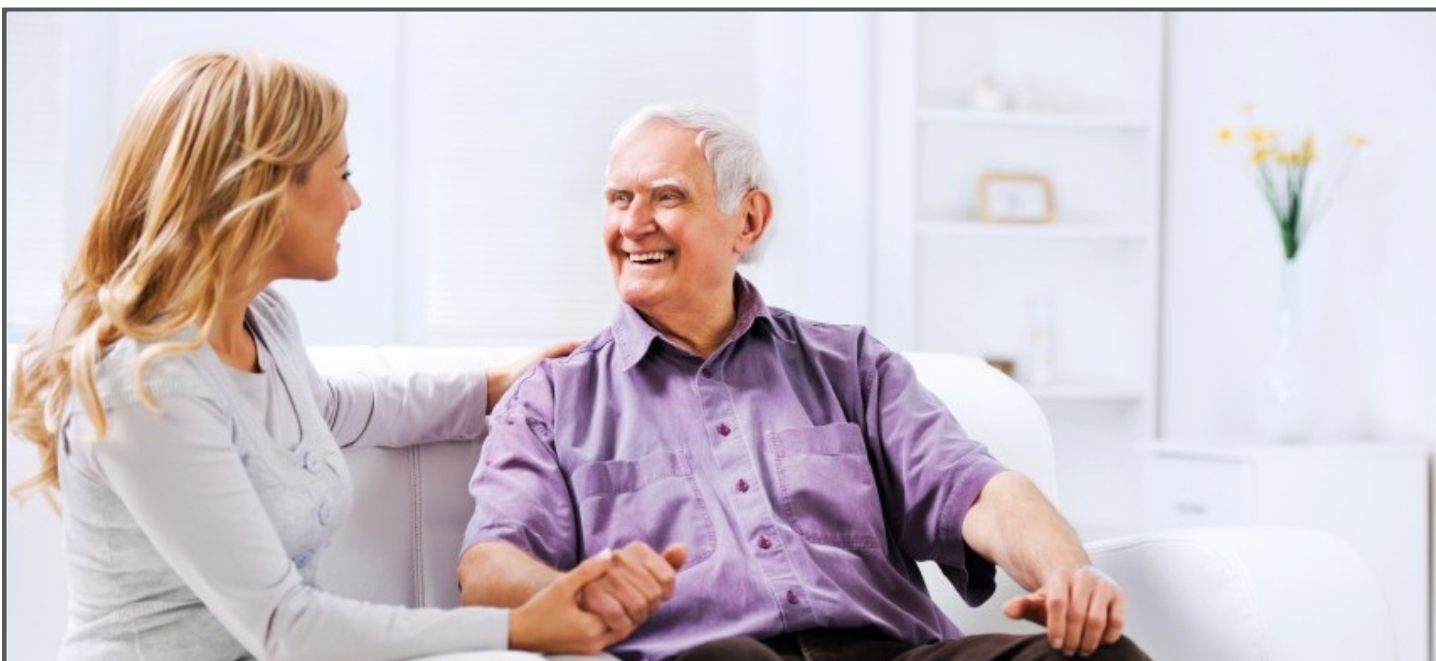

Going from hospital to home? Feeling overwhelmed?
Transitional Care Services can help.

Transitional Care Services provides you with a Care Coordinator to help make your transition from hospital to home easier.

At the Hospital
Your Care Coordinator will meet with you and your family in your hospital room to understand your needs and to set up services prior to your discharge.

At Home
One or two days after you are discharged from the hospital, your Care Coordinator will visit or call you at home. You may find you have some new needs once you return home. Your Care Coordinator can help you understand and address discharge instructions, transportation issues, physician follow-up, home health care, and understand and obtain medications.

Follow Up
Over the next few weeks, your Care Coordinator will check in with you periodically to make sure your transition home is going well.

To learn more call 888-637-6060 (Clark) or 800-682-2406 (Cowlitz) and ask about Transitional Care Services

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