DOCTOR'S APPOINTMENTS

Bring this form with you for his/her review, and w/ regard to medications, he/she can provide prescriptions for any necessary refills.

☐ A post-discharge appointment has been scheduled with

Dr. _____ (YOUR PCP)

located at _____

on _____ at _____ ☐ A.M. / ☐ P.M. for

_____

Phone # _____ Fax# _____

☐ A post-discharge appointment has been scheduled with

Dr. _____

located at _____

on _____ at _____ ☐ A.M. / ☐ P.M. for

_____

Phone # _____ Fax# _____

☐ A post-discharge appointment has been scheduled with

Dr. _____

located at _____

on _____ at _____ ☐ A.M. / ☐ P.M. for

_____

Phone # _____ Fax# _____

☐ You are advised to schedule a post-discharge appointment with

Dr. _____

for _____

Phone # _____

☐ You are advised to schedule a post-discharge appointment with

Dr. _____

for _____

Phone # _____

NURSING

D/C Order Obtained ☐ Yes ☐ No Order for Home Care Obtained ☐ Yes ☐ No

RECAP OF STAY

Reason for Admission/Initial Discharge Goals/Were Discharge Goals Met

Diagnoses

Course of Illness/Any ER Visits or Hospitalizations During Stay(if so, include name of hospital)/Consultation Results

*BEHAVIOR HEALTH/PATTERNS

MENTAL STATUS

Cognitive Status/Awareness	☐ Alert	☐ Semi-Comatose	☐ Comatose
*Learning Ability	☐ Good	☐ Fair	☐ Poor
Orientation	☐ Good	☐ Fair	☐ Poor
Long-Term Memory	☐ Good	☐ Fair	☐ Poor
Short-Term Memory	☐ Good	☐ Fair	☐ Poor
Presence of Thought Disorder	☐ Present	☐ Absent	☐ By History
Affective Disorder (i.e. depression, symptoms of depression)	☐ Mild	☐ Moderate	☐ Severe

NURSING

OTHER MEDICAL

Weight: Height:

Incontinent Care: ☐ Bladder ☐ Bowel ☐ Catheter ☐ Ostomy Care

Impairments: ☐ Vision ☐ Hearing ☐ Speech ☐ Other:

Hearing: ☐ **Left Aide** ☐ **Right Aide** ☐ **None**

Dental Condition: ☐ **Own Teeth** ☐ **No Teeth** ☐ **Upper Dentures**

☐ **Lower Dentures** ☐ **Partial Dentures** ☐ **Refuses To Wear Dentures**

Allergies: ☐ Yes ☐ None Known

Details

Pertinent Clinical Lab Values/Diagnostic Tests:

***Skin Condition/Special Treatments/Wound Care:**

Diabetic Care:

***Chronic Diseases/Symptoms/Dialysis:**

Addiction History:

Pain Management Assessment and Teaching:

Respiratory Needs:

***Palliative Care/Goals**

Education Regarding Adherence to Plan of Care to Prevent Readmission Across Care Setting:

DISCHARGE MEDICATIONS

Patient Name _____ **DOB** _____

Allergies _____

Physician Name _____ **Phone #** _____

Pharmacy _____ **Phone #** _____ **Fax#** _____

Address _____

Prescriptions for the medications listed on the grid(s):

- ☐ Have been provided to you at discharge
- ☐ Have been called into your pharmacy and are ready for pick-up
- ☐ Have been called into your pharmacy and will be delivered to you

☐ ***Additional Meds Listed on Second Grid***

MEDICATION(S) PRESCRIBED	ROUTE	DOSE	REASON / DIAGNOSIS	SIDE EFFECTS	INSTRUCTIONS (INCLUDING FREQUENCY)

IMPORTANT MEDICATION NOTE(S):

*History of Non-Compliance ☐ No ☐ Yes (Details)

*Affordability Issues ☐ No ☐ Yes (Details and Actions Taken Toward Rectifying the Issues)

OTHER: *NURSING UNIT PHONE #:

***DO NOT TAKE OTHER MEDICATIONS/SUPPLEMENTS/VITAMINS OTHER THAN WHAT IS LISTED UNTIL CLEARED BY DOCTOR**

Typed or Printed Name of Person Completing Nursing Section | Signature of Person Completing Nursing Section | Date

RESIDENT/RESIDENT REPRESENTATIVE SIGNATURE

My signature on this form represents that the content within this entire discharge package has been explained to me that I understand what has been explained. I'm aware that I have the right to appeal this discharge to the Office of the Ombudsman and/or the State Department of Health and Human Services.

Signature | Date

****On behalf of our staff, we thank you for choosing _____ for your healthcare needs. If you require any assistance in the future, our staff stands ready to assist you.

COPY OF DISCHARGE PLAN GIVEN TO:

☐ RESIDENT ☐ RESIDENT REPRESENTATIVE ☐ CARE NAVIGATOR ☐ ACO ☐ PHYSICIAN SPECIALIST ☐ PBCI ☐ PHT

☐ PCP (IF NO, EXPLAIN): _____

DISCHARGE MEDICATIONS *con't…*

Patient Name _____ **DOB** _____

MEDICATION(S) PRESCRIBED	ROUTE	DOSE	REASON / DIAGNOSIS	SIDE EFFECTS	INSTRUCTIONS (INCLUDING FREQUENCY)