Patient Name: _____ Admission Date:

Disposition: ☐Skilled Nursing (Facility Name:_____)
☐Nursing Home (Facility Name:_____)
☐Rehab Facility (Facility Name:_____)
☐Hospice (Facility / Agency Name:_____)
☐Home with Home Health (Agency Name:_____)
☐Personal Care Home
☐Home without Home Health

Dietary Instruction/Needs
Diet: _____ Oral Supplement(s):
Tube Feedings: _____ @_____cc/hr + _____ml free water q _____ hrs
Additional Dietary Instruction: _____

Rehabilitation Instructions/Needs and Functional Status Transfers: Gait / Ambulation:
ADLs/Dressing:_____ Toileting: _____
Equipment Needs: ☐ Walkers ☐ Wheelchair ☐ Hospital Bed ☐ Lift
☐ Other
Swallowing/Communication:_____
Comments/Instructions: _____

Wound Management
☐See Attached Orders ☐ Wound Vac ☐ Specialty Bed:____ Dressing/Wound
Care Instructions: _____

Follow-up Appointment:

Respiratory Instructions/Needs:
☐ Oxygen via_____@ _____1 or % ☐ Nebulizer(s):
☐ Ventilator (Settings:_____) ☐ BiPAP
Patient/family training complete including returns demonstrations:

Oxygen therapy	Y	N	N / A
Tracheostomy care	Y	N	N / A
Suctioning	Y	N	N / A
Nebulizer Treatment	Y	N	N / A
Ventilator/BiPAP	Y	N	N / A

Other Equipment/Instructions:

Case Management:

Home Health Services Ordered:_____

Home Health Agency Contact: Name:_____Phone #: _____

DME Arrangements: Equipment: _____

Company Name: _____ Phone #:_____

Dialysis Arrangements: _____

Other Comments and Instructions: _____

_____

_____

Nursing and Miscellaneous Instructions/Needs

Vascular Access: Site: _____ Catheter type: _____Date Inserted: _____

Foley Catheter: Type: _____ Date inserted: _____

Date Discontinued: _____

If within 24 HRS of D/C:

Patient Voided: X 1_____ Amount _____

X 2_____ Amount _____

Other Indwelling catheters:

_____

Other Instructions:

_____

Medications

Discharge Medication List Completed and reviewed with patient/family Y N

Prescriptions given to patient/family: Y N

_____

Checklist:

Discharge order on chart Y N

Patient has collected personal belongings **including those in the safe:** Y N

Vital Signs taken < 2 hours prior to discharge: T____ P____ R_____ BP____02 Sat____

Discharge Parameters: Fever, if any, resolving

Heart Rate 50 -100min

Respiratory Rate 10 – 20

Systolic BP 90 – 160

Oxygen Sat (if applicable) ≥ 91 %

Vital Signs within above parameters: Y N

If "N", was physician notified? Y (Date/Time _____) Comments:

_____

_____

Follow-up Appointment with Physician: Name: _____ Phone: _____

Date: _____ Time: _____

Patient leaving via:☐ Private vehicle ☐ Ambulance ☐ Other _____

Accompanied by: _____

Signature: Discharging Nurse:_____ Patient/Provider: _____

Date and Time of Discharge: _____