DISCHARGE TEMPLATE (LONG TERM CARE)

Primary NH Admission Dx: ____________________________________________

Secondary Admission Dx: ____________________________________________

Other Admission Dx: ________________________________________________

APS case/special instructions:________________________________________

Code Status: Full/DNR/OOH DNR/No artificial feeds/hydration/DNH

DPOA/POA/Guardian/Proxy Contact No: _____________________________

VS: routine/other (NH VS: __________________ O2 Sat: RA ___/___ on ___ L/NC)

PAIN: location/description/Tx. Meds __________________________________

Last BM ____________________ Bowel regimen _______________________

Cognition: Not impaired/Impaired with decisional capacity/Impaired without decisional capacity/eloement risk

Function: Full wt. Bearing/Modified wt.bearing/wc/walker* Fall risk/amb. with assistance only *Scripts

BOWEL: continent/incontinent BLADDER: continent/incontinent

HHC REHAB CANDIDATE: good/bad Evaluation: PT &/or OT (see PT/OT / ST recs. and MBBS)

ACCESSORIES: hearing aide- inilateral, bilateral/dentures – upper/lower

ALLERGIES/Associated symptoms: _________________________________

DIET: Regular/Modified: ___________________________________________

Tube feedings: NG/PEG/GT Type of nutrition: ___________ Residuals: ________

Administration orders: _____________________________

LINES & TUBES: Type: __________ insertion date ________ d/c date ______

Pacemaker/Internal Defibrillator: Last interrogated ______________________

Hemodialysis/dialysis days: _____________________________

ACCUCHECKS: AC&HS/other _____________________________

PRESSURE ULCER(S): Location/TX/Supplies* ____________________________ *Scripts

PERTINENT LABS & IMAGING TEST RESULTS: PT/INR ______ DATE ______

On ___________ Coumadin/day NEXT PT/INR DUE DATE: _______________

INR Goal: _______ Other: CBC(S) _____________________________

CHEM 7 ___________________ LIFT'S __________________ OTHER: __________

IMAGING STUDIES: __________________________________________________

INFECTION/ISOLATION TYPE/TREATMENT: ____________________________

ACTIVE/INACTIVE/colonized

MEDICATIONS/INDICATION/STOP DATE/SPECIAL RECS. (if indicated)*: ____________________________ *Scripts attached

MD F/U VISITS: F/U with PCP/Specialist: ______________________________

DISCHARGING MD: ___________________________ PAGER: __________________

DATE: ____________________________________________________________

July 4, 2007