

# DISCHARGE CARE PLAN

From In-patient agency

From Home Care

Referral to Home Care for:

None  Meals

Nursing Care  Physiotherapy

Personal Care  Occupational Therapy

Home Maintenance  Other:

## INSTRUCTIONS FOR CARE

PERSONAL HYGIENE  Independent  Handout (name and dept):

ELIMINATION  Independent  Handout (name and dept):

NUTRITION  Independent  Handout (name and dept):

MOBILITY  Independent  Handout (name and dept):

OBSERVATIONS AND MEASUREMENTS  Handout (name and dept):

MEDICATIONS  Copy of current medication records attached:  Reconciled

Medication Administration Record

Prescription:  Yes  No

Own Medications Returned:  Yes  No

TREATMENTS and Procedures  Handout (name and dept):

Dressings  Yes  No

Packing  Yes  No (If yes, describe, including count)

TEACHING  Handout (name and dept):

SAFETY  Handout (name and dept):

PSYCHOSOCIAL  Handout (name and dept):

HOME CARE PLAN  Yes  No  Practitioner orders/discharge instructions provided to home care

Copy of Advance Care Plan/Goals of Care order with patient and to home care

APPOINTMENTS  Made for you  Make your own appointment

NAME

LOCATION

TIME/DATE

TELEPHONE

Show this plan to your home care provider(s) and take it to your next doctor's appointment

Information reviewed by patient/family/significant other and caregiver and consent to send Medication list to Pharmacy  
Signature: \_\_\_\_\_ Signed \_\_\_\_\_

Date

Jan 16

ID

TW RN

White copy – to patient Yellow copy – patient record

3sHealth, NISS Copyright. Not to be reproduced in any manner.

DCP-102.7 OCT, 2016

# SEPARATION SUMMARY

- from Acute Care
- from Long Term Care
- from Home Care

Date/Time: Jan 16

**OUTCOME/DISCHARGED TO:**  Improved, remains at home  
 Home  
 Special Care Home (*specify*) \_\_\_\_\_  
 Other facility (*specify*) \_\_\_\_\_

**MODE:**  NA  Ambulatory  Wheelchair  Stretcher  Carried

**BELONGINGS SENT WITH PATIENT:**  NA  Yes  No (*specify*)

**WHO CAME FOR PATIENT:**  NA taxi  
*(name and relationship):*

PATIENT STATUS	INDEPENDENT	PARTIALLY DEPENDENT	DEPENDENT	N/A	COMMENTS
Hygiene function	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel function	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder function	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food and fluid intake	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to feed self	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to use mobility devices	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to use medications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to carry out treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Overall ability to function	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<b>Yes</b>	<b>No</b>	<b>N/A</b>		
Orientated (3 spheres)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Appropriate behaviour	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Emotional status	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		

Satisfied with care/services:  Yes  No

If not, what would have made it better:

is experiencing increasing depression with dependency and frequency of care.

Understands how to obtain future assistance:  Yes  No

If yes, check all that apply:  from home care  for emergency care  from physician

If no, explain:

See Notes

TW RN

ID: \_\_\_\_\_