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): ref to home care

ELIMINATION ☐ Independent ☑ Handout (name and dept): ref to home care

NUTRITION ☐ Independent ☑ Handout (name and dept): ref to home care

MOBILITY ☑ Independent ☐ Handout (name and dept):

amb ind with 2ww min. practice 4ww 50m/day and practice transfer from sit to stand.

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

consider stop naproxen, start acetaminophen for pain.

consider stop ASA

consider reduce or taper off zopiclone

review medications, referred to home care

TREATMENTS and Procedures ☐ Handout (name and dept): ( ) Blood product notification provided

Dressings ☐ Yes ☑ No

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

TEACHING ☑ Handout (name and dept): (x) Copy Allergy/Intolerance Record provided or ( ) N/A - no allergies

OT: compensatory strategies with ADLs

SAFETY ☑ Handout (name and dept):

OT: practice ADLs.

PSYCHOSOCIAL ☐ Handout (name and dept): ref to home care.

further cognitive assessment needed.

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 6	ID DE RN

White copy – to patient Yellow copy – patient record

SEPARATION SUMMARY

☑ from Acute Care
☐ from Long Term Care
☐ from Home Care

Date/Time: Jan 6

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 services
(name and relationship):

PATIENT STATUS	INDEPENDENT	PARTIALLY DEPENDENT	DEPENDENT	N/A	COMMENTS
Hygiene function	☐	☑	☐	☐	
Bowel function	☑	☐	☐	☐	
Bladder function	☐	☑	☐	☐	
Food and fluid intake	☑	☑	☐	☐	
Ability to feed self	☑	☐	☐	☐	
Mobility	☑	☐	☐	☐	
Ability to use mobility devices	☑	☐	☐	☐	
Ability to use medications	☐	☑	☐	☐	
Ability to carry out treatments	☐	☑	☐	☐	
Overall ability to function	☐	☑	☐	☐	

	YES	NO	N/A
Orientated (3 spheres)	☑	☐	☐
Appropriate behaviour	☑	☐	☐
Emotional status	☑	☐	☐

Satisfied with care/services: ☑ ☐

If not, what would have made it better:

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

ID: DE RN