Discharge Summary

Section 1: For All

Consumer Name_______________________________ Primary Physician Name_________________________________

Consumer Medicaid Number __ __ __ __ __ __ __ __ __ __ __ __

Date Service Started __ __/__ __/__ __ __ __ Date of Discharge __ __/__ __/__ __ __ __

Service Provided ___RN ___LPN ___Personal Care Aide

Consumer Diagnosis:________________________________, ________________________________
Allergies:________________, _______________, ______________, _______________
Diet: ____

Alert ____Yes ____No **Oriented to: person** ___Yes ___No **Place** ___ Yes ___ No **Time** ___Yes ___ No

Disability: **Vision** ___Yes ___**No** **Hearing** ___ Yes ___ No **Language** ___ Yes ___ No
Comments:____
____
____

Advanced Directives: ___ Yes ___ No Where Located: ____
DNR ___Yes ___ No

Requirements for Activities of Daily Living (Place "X" under area that applies to consumer)

Patient Activity	**Partial Assistance**	**Total Assistance**	**No Assistance**
Bathing/Personal Care	________	________	________
Skin Care/ Wound	________	________	________
Ambulation	________	________	________
Turning & Positioning	________	________	________
Transfers	________	________	________
Bowel Elimination	________	________	________
Bladder Elimination	________	________	________
Nutrition	________	________	________
Treatments	________	________	________

Commemts:____
____
____

Section 2: For Nurses Only

Vital Signs: Temp_____ Pulse_____ Respirations _____ BP _____

Medications (Frequency and Dosage)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Equipment ____

*Consumer Name*________________________

Physicians Orders

Physicians Orders	Interventions	Consumer Outcomes

Section 3: For All
Reason for Discharge

____ No longer requires service
____ Entered Hospital
____ Entered Long-Term Care Facility
____ Consumer Withdraw Request For Service
____ Not under Care Of Physician
____Referred to Another Provider For Reason Other Than Reimbursement
____ No Source Reimbursement
____ Physician Discontinued Order for Service
____ Unsafe Conditions/Environment
____ Other________________________
____ Moved from Geographic Service Area.
____ Non-Compliant With Delivery of Service
____ Change in Source Reimbursement

Discharge Summary (Physiological, social, spiritual, educational needs and progress, knowledge about illness, coping ability, support systems pertinent to goals of discipline)______________________

____
____
____
____

Instructions Given To Consumer/Responsible Party____

____
____
____
____

Consumer/Responsible Party Understands Instructions: ___Yes ___ No

Signature of Provider ____ **Date** __ __/__ __/__ __ __ __

Signature of Consumer or Responsible Party ______________________________________ **Date** __ __/__ __/__ __ __ __