# Continuity of Care **Discharge/Transfer of Patient Form**

Use this form when permanently discharging or transferring a patient from your facility.

**Affix imprint or label here.**

Admission Date: Discharge Date:

Patient Name:

Home Address:

Discharged to:

Address:

Phone: ( ) -

**Discharging facility contact person:**

Phone: ( ) -

**The following information MUST be attached for discharge to a nursing or other facility:**

☐ Patient demographic/registration sheet
☐ Medications and IV sheets ☐ Most recent lab results

| Principal diagnosis upon admission: | Surgery this admission: | Date: | Other active medical problems: |
|---|---|---|---|
| Allergies (list and describe reactions): | Active infection(s) in existence this admission and site: | | |

**Physician treatments/orders - Please specify number and frequency:**

Diet:

**Condition at discharge:** ☐ Improved ☐ Unchanged from admission
☐ Skilled Home Nursing Care
☐ Physical Therapy ☐ Respiratory Therapy
☐ Occupational Therapy ☐ Speech Therapy

**Additional physician comments:**

**List ALL medication(s) to be taken after discharge: (Include dose and frequency. Indicate if medication is new.)**
**NOTE: Nursing homes must have prescriptions for Schedule II medications.**

**New prescriptions:** ☐ were ☐ were not provided

**Instructions until next doctor visit**

| | Allowed | Allowed with supervision | Not allowed |
|---|---|---|---|
| Drive car or ride a bike | | | |
| Ambulation | | | |
| Shower/tub bath | | | |
| Housework | | | |
| Lifting (weight limit lbs.) | | | |
| Contact with non-clinical people | | | |
| Weight bearing | | | |
| Stair climbing | | | |
| Participation in gym class | | | |
| Contact/non-contact sports | | | |
| Return to work/school/class | | | |
| Resume sexual activity | | N/A | |

**Attending physician's signature:**

Date:

Discharge summary dictated by: (please print)

**Physician who will follow this patient after discharge:** (please print)

Name: Phone: ( ) -

Physician notified: ☐ Yes ☐ No

| ORIGINAL: Agency/patient | COPY: Physician(s)/agency | COPY: Chart |
|---|---|---|

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Patient Name:

**Does the patient have documents for end-of-life care?**

☐ MOLST ☐ DNR ☐ DPA

**Immunization(s) this admission:**

☐ Flu ☐ Pneumonia

**Isolations/Precautions**

| | Positive Culture | Site | Date Resolved | Prior History |
|---|---|---|---|---|
| **MRSA** | | | | |
| **VRE** | | | | |
| **C.Diff.** | | | | |
| **ESBL** | | | | |
| **CRE** | | | | |
| **TB** | | | | |

**Discharged to:**

☐ Home ☐ Home care/services ☐ Rehab ☐ Nursing home ☐ Other:

**Referral to:**

Agency: Phone: ( ) -

Visit(s) scheduled for:

## Information given to patient on discharge:

☐ Written information on medications
☐ Food/drug interaction information
☐ Drug/drug interaction information
☐ Pain management instructions
☐ Therapeutic diet instructions
☐ Smoking cessation brochure
☐ Congestive heart failure brochure
☐ Comfort-One Band

Call physician if:

Wound care instructions:

Follow-up appointments with phone numbers:

## Medications:

Nurse includes the actual time(s) prescription(s) are to be taken and the next time the drug is due.

| Pre-admission | New | Dose | Frequency | Time last given | Time next dose | **Continue after discharge** Yes | No |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | | | | | |
| ☐ | ☐ | | | | | | |
| ☐ | ☐ | | | | | | |
| ☐ | ☐ | | | | | | |
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| ☐ | ☐ | | | | | | |
| ☐ | ☐ | | | | | | |
| ☐ | ☐ | | | | | | |

**Comments:**

Nurse's signature: Title:

Date: Phone: ( ) -

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RHODE ISLAND DEPARTMENT OF HEALTH

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## Physical and Functional Status Nurse Form

Patient Name: Date:

**Activities of daily living on discharge day**

**CODES:**

**0** = Independent
**1** = Supervision
**2** = Limited Assistance
**3** = Extensive Assistance
**4** = Total dependance
**5** = Activity did not occur

| | |
|---|---|
| Transfer | Walking |
| Dressing | Eating |
| Toileting | Bathing |
| Personal hygiene | |

| **Mobility:** | Normal | Impaired |
|---|---|---|
| Upper extremities | | |
| Lower extremities | | |

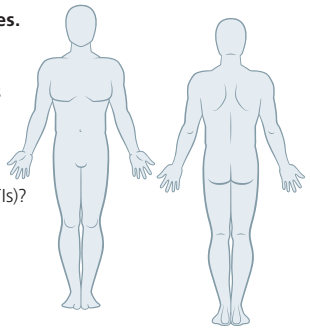
☐ Amputee

☐ Prosthesis use

☐ Equipment needed on discharge

**Diagram stage and location of all pressure injuries.**

**Stg 1** - non-blanchable erythema of intact skin
**Stg 2** - partial-thickness skin loss with exposed dermis
**Stg 3** - full-thickness skin loss
**Stg 4** - full-thickness skin and tissue loss



**Other wounds present** (include unstageable and DTIs)?

☐ No ☐ Yes – Describe:

| **Bowel and bladder assesment** | Bladder | Bowel |
|---|---|---|
| Continent | | |
| Occasionally incontinent | | |
| Frequently incontinent | | |
| Incontinent | | |

Date of last bowel movement:

Ostomy (*type/size*):

Foley type: balloon size:

Date foley changed:

☐ Dialysis (*type*):

**Vital signs**

Height: Weight:

Pulse range: Resp. range:

Temp: Blood pressure:

On oxygen @ LPM Pulse oximeter range:

**Pain score:**

0 1 2 3 4 5 6 7 8 9 10

No pain — Mild — Moderate — Severe — Worst pain imaginable

Describe pain:

**Cognitive skills for daily descision making**

How well does the patient make decisions about organizing the day?
*(Choose one response)*

☐ Independent
☐ Modified independence - some difficulty in new situation
☐ Moderately impaired - descisions poor, cues/supervision needed
☐ Severely impaired - never or rarely decides

Level of consciousness?
*(Choose one response)*

☐ Alert
☐ Drowsy, but aroused with minor stimulation
☐ Requires repeated stimulation to respond
☐ Responds only with reflex motor or autonomic system
☐ Unresponsive

**Brief mental health examination**

Patient is oriented to:

Person ☐ Yes ☐ No Place ☐ Yes ☐ No Year ☐ Yes ☐ No

Thought or speech organization is coherent ☐ Yes ☐ No

Maintains attention, not easily distracted ☐ Yes ☐ No

Short term memory OK - recalls 3 items after 5 minutes *(i.e., book, tree, house)* ☐ Yes ☐ No

**Communication**

Primary Language:

Able to: ☐ Understand ☐ Speak ☐ Read ☐ Write

Secondary Language:

Able to: ☐ Understand ☐ Speak ☐ Read ☐ Write

Aphasia: ☐ Expressive ☐ Receptive

Sign language: ☐ Yes ☐ No

## Impairments - Hearing/Visual

**Auditory** (with hearing appliance, if used)

☐ Hears adequately ☐ Has hearing device
☐ Minimum difficulty Type:
☐ Intermittently impaired
☐ Highly impaired

**Vision** (with glasses, if used)

☐ Sees adequately ☐ Has visual device
☐ Impaired - sees large print but not regular print Type:
☐ Moderately impaired - limited vision, cannot see headlines
☐ Severely impaired - no vision or only sees light, color, shapes

**Comments:** (if necessary to describe any deviation not addressed in nursing discharge summary):

Nurse's signature: Title:

Date: Phone: ( ) -

ORIGINAL: Agency/patient COPY: Physician(s)/agency COPY: Chart

# Continuity of Care **Discharge/Transfer of Patient Form**

## Discipline Specific Summary Notes

Patient Name: Date:

Discipline: *Nursing discharge summary* IV present ☐ No ☐ Yes – Complete next line:

Date IV started: Time: IV solution Meds in IV Rate:

Signature: Contact#/Unit Date:

Discipline: Additional information attached: ☐ Yes ☐ No

Signature: Contact#/Unit Date:

Discipline: Additional information attached: ☐ Yes ☐ No

Signature: Contact#/Unit Date:

This information was reviewed and new prescriptions ☐ were ☐ were not provided. I understand these instructions and accept responsibilty to carry them out and bring this form to my next doctor/clinic appointment

Patient signature:

*Or if discharged to parent/guardian - name(s)/signatures*

Interpreter(s) name:

ORIGINAL: Agency/patient COPY: Physician(s)/agency COPY: Chart