POST DISCHARGE PLAN OF CARE

RESIDENT: _____ Hospital # _____

Plan developed with the ☐ Resident ☐ Responsible Party (Complete for Home and Board & Care))

Admit Date: _____ **Discharge Date:** _____

Transferred to: _____

1. Physician Visit Appointment Date _____ ☐ Contact Physician & Schedule

Physician: _____ Phone #: _____

Address: _____

_____

2. POST DISCHARGE PLANS/COMMUNITY AGENCIES

☐ Home Health

☐ Meals on Wheels Ph # _____

☐ Private Duty Nurse Ph # _____

☐ Therapy (PT-OT-ST) Ph # _____

☐ Counseling/Psychiatric Care Ph # _____

☐ Other _____

AGENCY/CONTACT:

Name: _____

Address: _____

Phone #: _____

Purpose: _____

Contact _____

3. EQUIPMENT NEEDS (S=Sent, N=Need)

S / N Commode S / N Special Bed

S / N Wheelchair S / N Splint

S / N Walker S / N Other _____

S / N Cane _____

_____

4. SPECIAL OBSERVATIONS

(To be reported to the physician)

_____

_____

_____

_____

5. SPECIAL TRAINING/INSTRUCTIONS:

☐ Injections ☐ Accuchecks

☐ Dressing Change ☐ Colostomy Care

☐ Foley Catheter Care ☐ Blood Pressure "How to take"

☐ Meal Preparations / Special Diet ☐ Pulse "How to take"

☐ Tube Feeding / Administration ☐ Treatment (Site) _____

Stage / Size) of decubitus

_____

_____

Additional Notes regarding Instructions/Discharge

_____

_____

_____

_____

_____

_____

6. MEDICATIONS (These medications are released in non-childproof containers.)

MEDICATIONS	FREQUENCY	SPECIAL INSTRUCTIONS	AMOUNT RELEASED

COMPLETED BY: _____ DATE: _____

ID TEAM REPRESENTATIVE

(My signature below certifies that I have received and understand the instruction outlined above.)

ACCEPTED BY: _____ DATE: _____

RESIDENT / RESPONSIBLE PARTY