

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
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S / N	Wheelchair	S / N	Splint
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S / N Walker	S / N Other
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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 / ☐ Pulse "How to take"Special Diet ☐ Treatment (Site)☐ Tube Feeding / Stage / Size) of decubitus

Administration

Additional Notes regarding

Instructions/Discharge

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

[illegible]

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