### Patient Identification

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>(Military Time)</td>
<td></td>
</tr>
<tr>
<td>Surgeries:</td>
<td></td>
</tr>
<tr>
<td>Mode of Arrival</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Arrival From:</td>
<td></td>
</tr>
<tr>
<td>STRETCHER</td>
<td>WHEELCHAIR</td>
</tr>
<tr>
<td>Level of Consciousness / Mental Status</td>
<td></td>
</tr>
<tr>
<td>Fully awake and alert</td>
<td></td>
</tr>
<tr>
<td>Drowsy: easily arousable</td>
<td></td>
</tr>
<tr>
<td>Oriented X ___ to: person / place / time</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

### Vitals

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Temp:</td>
<td></td>
</tr>
<tr>
<td>BP:</td>
<td></td>
</tr>
<tr>
<td>Resp:</td>
<td></td>
</tr>
<tr>
<td>Pulse:</td>
<td></td>
</tr>
<tr>
<td>Oxygen Sat:</td>
<td></td>
</tr>
</tbody>
</table>

### Discharge Plan of Care

#### I. Level of Consciousness / Mental Status

- Fully awake and alert
- Drowsy: easily arousable
- Oriented X ___ to: person / place / time
- Other:

#### II. Transfers From Stretcher / Wheelchair to Recliner

- Transfers from Stretcher / Wheelchair to Recliner:
  - Easily with stand-by assistance; steady to feet
  - Unsteady on feet and required assistance due to:
  - Other:

- Ambulation:
  - Independent with steady gait
  - Gait unsteady and assistance required
  - Demonstrates safe ambulation w/ (if applicable)
    - Crutches
    - Cane
    - Walker
    - Post-Op Shoe
  - Non-ambulatory: bedridden / wheelchair - bound
  - Weight bearing tolerance of operative extremity:
  - Other:

- *Describe problems, if any.

#### III. Fluid Intake (Oral and Intravenous):

- Drinking adequate oral fluids w/ out problems
- Type of Liquids Amount
- * Describe problems, if any.
- Peripheral IV - Type / Location and Patency:
  - Total amount of volume infused
  - IV discontinued @ by
  - Condition of site is clear

#### IV. Surgical / Dressing Site Assessment:

- Location:
  - DRESSING: DRY / INTACT
  - CHANGED DRAINAGE (COLOR / AMOUNT)

- Other Surgical / Dressing Site?
  - None
  - Yes

- Ice Pack Applied to:

#### V. Peri-Vascular Assessment to Operative Extremity:

- Skin: Elevated?
  - No
  - Yes
- Skin Temp:
- Color:
- Ability to Move:
- Sling Given:
- Numbness / Tingling:
- Dialysis Patients Only-Bruit Present?
  - Yes
  - No
- Other:

#### IV. Voiding Assessment:

- Not required per discharge criteria
- Reported voided without any problems.
- Urinary catheter in place - describe type / amount of output:
- Instructions reviewed for care of catheter
  - *Describe problems, if any
  - Other:

### Part of the Medical Record

8850229 Rev 05/05

In and Out Surgery Discharge Assessment OR

Page 1 of 2
PAIN LEVEL: DESCRIBE TYPE & LOCATION OF PAIN:

*Rate the intensity of pain (on barscale below):

<table>
<thead>
<tr>
<th>WONG-BAKER:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10 VISUAL:</td>
<td>No Hurt</td>
<td>Hurts Little Bit</td>
<td>Hurts Little More</td>
<td>Hurts Even More</td>
<td>Hurts Whole Lot</td>
<td>Worst Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VERBAL: No Hurt, Hurts Little Bit, Hurts Little More, Hurts Even More, Hurts Whole Lot, Worst Pain

NON-COGNITIVE: (FLACC Score)

1. Sum FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY scores to calculate FLACC Score.
2. Record FLACC Score w/ 0-10 Numeric Scale above.

**Describe problems of pain and effectiveness of Analgesic(s) if given:**

- Reportedly free of pain / discomfort
- Pain level at time of Discharge

NURSING ASSESSMENT / OBSERVATION

- Physicians Order Sheet reviewed
- Verbally reviewed with:
- Written discharged instructions signed and given to:
- Post Op teaching given for
- Type of supplies / Eye Kit given for home use

NURSING ASSESSMENT / OBSERVATION

- Discharging MD:
- Discharge criteria met?
- Patient dressed with supervision?
- Valuables returned to and identified by patient
- Patient Belongings Sheet signed
- Prescriptions reviewed & given

DISCHARGE PREPARATION:

- List any:

DISCHARGE ASSESSMENT

- Patient discharged via:
  - Wheelchair
  - Alone
  - Ambulatory
  - Ambulance
  - Other:
  - Patient discharged from unit at (Military Time)

STANDARD DISCHARGE PLAN OF CARE IMPLEMENTED:

- Escorted by staff member to vehicle / other to the care of:
- Phone number where patient may be reached tomorrow:

STANDARD OUTCOMES ACHIEVED WITHOUT DIFFICULTY:

- If "NO", Explain Exception:

INDIVIDUAL PLAN OF CARE:

- SPECIFIC NEED
- EXPECTED OUTCOME
- NURSING ORDERS

ALLERGIES (list):

| TIME | MEDICATIONS GIVEN | DOSE | ROUTE | NURSE'S SIGNATURE / TITLE |

DATE / TIME

NURSING NOTES

SIGNATURE:  
TITLE:  
DATE:  
TIME:  (Military Time)