UNIVERSITY MEDICAL CENTER

PATIENT DISCHARGE SUMMARY

AFFIX PATIENT INFO LABEL HERE

Patient Name ______________________ **MR#** ____________

Discharge Date: ____________________ **Time:** ______________

DISCHARGED VIA:
- ❑ Wheelchair
- ❑ Ambulatory
- ❑ Ambulance

DISCHARGED TO:
- ❑ Home
- ❑ Rehab Facility
- ❑ Subacute
- ❑ Long Term Care
- ❑ Hospice
- ❑ Other ______________

ACCOMPANIED BY: ____

DISCHARGE VITAL SIGNS: BP:______ / ______ Pulse: ______ Resp: ______ Temp: ______ Weight: ______ Blood Sugar: ______

Barrier(s) to communication/learning: ____

Steps taken to overcome barrier(s): ____

Follow-up education needed: ____

DIET:
- ❑ No Restrictions
- ❑ Diet Consult Completed
- ❑ Diet Instructions Given for ______________
- ❑ Increase Intake of Clear Liquids

ACTIVITY AS TOLERATED: ❑
- ❑ Restrictions: ____
- ❑ Return to School/Work on: ______________________

WEIGHT MONITORING:

You should weigh yourself: ❑ Daily ❑ Weekly ❑ Other ______________________

SPECIALIZED DISCHARGE INSTRUCTIONS GIVEN FOR:
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ CHF
- ❑ COPD
- ❑ CVA
- ❑ Diabetes
- ❑ Influenza & Pneumococcal Vaccine
- ❑ Medications
- ❑ Myocardial Infarction
- ❑ Pneumonia
- ❑ Post Operative Care
- ❑ Weight Monitoring
- ❑ Wound/Incision Care
- ❑ Other ______________
- ❑ Other ______________

If patient is on Coumadin, Education Booklet Given ❑

❑ Follow-up Bloodwork (PT / INR) on: ______________

Smoking Cessation: If patient has smoked within the last year or lives with a smoker, Smoking Cessation Information Given ❑

FOLLOW UP WITH:
- ❑ Dr. ______________________ Phone: ______________ to arrange office visit within ______ days / weeks
- ❑ Dr. ______________________ Phone: ______________ to arrange office visit within ______ days / weeks

LAB WORK TO FOLLOW UP WITH: ______________________ Date ______________

REFERRALS:
- ❑ Home Care
- ❑ Speech Therapy
- ❑ Physical Therapy
- ❑ Social Services
- ❑ Occupational Therapy
- ❑ Other: ______________

EMERGENCY INSTRUCTIONS: Call 911 for persistent chest pain and shortness of breath or recurrence of symptoms that brought you to the hospital ____

____

PATIENT EDUCATION MATERIALS GIVEN TO PATIENT/FAMILY *(ex: Care Notes)*:

______________ ______________ ______________

______________ ______________ ______________

INSTRUCTIONS GIVEN TO: ____

COMMENTS / RESPONSE TO INSTRUCTIONS: ____

____

____

I have received and understand the above instructions given to me by the nurse / physician.

______________	______________	______________
PATIENT / REPRESENTATIVE SIGNATURE	*RELATIONSHIP TO PATIENT*	*DATE*

______________	______________
NURSE'S NAME (PLEASE PRINT)	*NURSE'S SIGNATURE*

UNIVERSITY MEDICAL CENTER

NURSING MEDICATION DISCHARGE INSTRUCTIONS

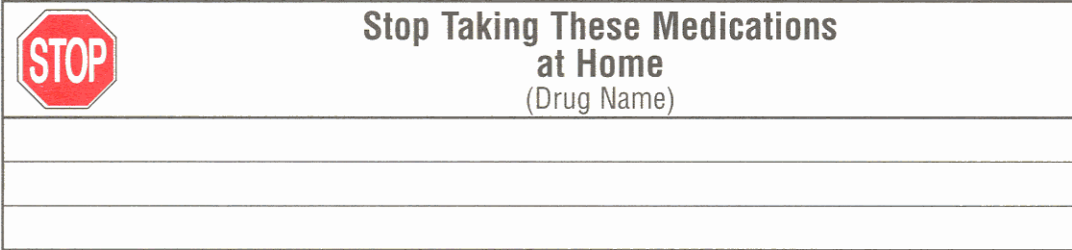
AFFIX PATIENT INFO LABEL HERE

Patient Name ______________________ MR# __________

❑ Flu Vaccine Date: __________

❑ Pneumococcal Vaccine Date: __________

* **Review Current Medication Profile, MAR, Admission Reconciliation Form for Reconciling ALL medications at discharge.**



Stop Taking These Medications at Home (Drug Name)	Allergies

New Medications to Start Taking at Home							
Drug Name	Dose	Route	How Often	How Long	Next Dose	Script Given	Reason for Taking/ Education
						❑ Yes ❑ No	
						❑ Yes ❑ No	
						❑ Yes ❑ No	
						❑ Yes ❑ No	
						❑ Yes ❑ No	

Continue Home Medications (continue until instructed to stop by your physician)					
Drug Name	Dose	Route	How Often	Next Dose	Reason for Taking/ Education

Fax to the following physician(s): ______________________________

Patient / Parent Signature: ____________________ Nurse's Signature: ____________________

Date/Time: __________

* **PLEASE TAKE THIS FORM TO YOUR NEXT PHYSICIAN APPOINTMENT**
* **NOTIFY YOUR PHYSICIAN IF YOU STOP TAKING ANY OF YOUR MEDICATIONS**