UNIVERSITY MEDICAL CENTER

PATIENT DISCHARGE SUMMARY

Discharge Date: ___________________________ Time: ___________________________

DISCHARGED VIA: ___________________________ DISCHARGED TO: ___________________________

☐ Wheelchair ☐ Home ☐ Rehab Facility
☐ Ambulatory ☐ Subacute ☐ Long Term Care
☐ Ambulance ☐ Hospice ☐ Other ___________________________

ACCOMPANIED BY: ___________________________


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

WEIGHT MONITORING: You should weigh yourself: ☐ Daily ☐ Weekly ☐ Other ___________________________

SPECIALIZED DISCHARGE INSTRUCTIONS GIVEN FOR: ___________________________________________________________________________

☐ Asthma ☐ CVA
☐ Atrial Fibrillation ☐ Diabetes
☐ CHF ☐ Influenza & Pneumococcal Vaccine
☐ COPD ☐ Medications

If patient is on Coumadin, Education Booklet Given ☐
☐ Follow-up Bloodwork (PT / INR) on: ___________________________

ACTIVITY AS TOLERATED: ☐ _______________________________________________________________________________________

☐ Restrictions: _________________________________________________________________________________________________

☐ Return to School/Work on: ___________________________

☐ Myocardial Infarction ☐ Wound/Incision Care
☐ Pneumonia ☐ Other ___________________________
☐ Post Operative Care ☐ Other ___________________________
☐ Weight Monitoring

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 ☐ Physical Therapy ☐ Occupational Therapy
☐ Speech Therapy ☐ Social Services ☐ 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: ___________________________

COMMMENTS / 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) ___________________________ PART OF MEDICAL RECORD ___________________________ NURSE’S SIGNATURE ___________________________ REV. 8/29/05 CHART COPY

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NURSING MEDICATION DISCHARGE INSTRUCTIONS

- 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)  

[Table for New Medications to Start Taking at Home]  
[Table for Continue Home Medications]  

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

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