INITIAL AND FINAL DISCHARGE PLAN

Patient Name ___________________________________________ Patient No. ________________________

Physician _______________________________________________ Admission Date _______________________

Diagnosis _________________________________________________

Responsible person ___________________________________________ Telephone _______________________

Discharge Plans at time of Admission to Swing Bed Program _______________________________________

Rehab potential: Excellent  Good  Fair  Poor  Negative

Goals for Discharge: Self Care  Family Care  HHA Services  Nursing Home Placement

Community Resources  Re-hab unit  Home with Hired Help  Lifeline unit

Location of patient prior to hospitalization: _______________________________________________________

Special Needs anticipated at time of discharge: ___________________________________________________

Diet _______________________________________________________

Therapy _____________________________________________________

Wound Care _________________________________________________

Medications _________________________________________________

Educational Needs _____________________________________________

Social and/or Environmental Needs: ___________________________________________________________

Have referral agencies been contacted: __________________________________________________________

If yes, list agency, date of contact and expected outcome. ___________________________________________

At time of discharge  Date ________________________________

Independence in ADLS _________________________________________

Nursing Service Assessment _______________________________________

Social Service Designee _________________________________________

Dietician Assessment ___________________________________________

Therapist Assessment (if any) _____________________________________

If final disposition of patient differed from initial plan, please state outcome, reason of change, and patient’s acceptance of change. _____________________________________________________________

See also nursing discharge summary for instructions. Date ___________________________ Discharge Coordinator (SB) ____________________________