COUNTY HOSPITAL

DISCHARGE INSTRUCTIONS

REFERRALS:  □ No referrals needed
            Name of Referred Service       Contact Number
            □ Home Health
            □ Equipment

SMOKING CESSATION
• If you smoke, it is VERY IMPORTANT to stop.
• Avoid secondhand smoke.
• Call your local health department to ask for services to help you stop.

DIET: □ No restrictions  □ Low fat / cholesterol  □ Instructions given
□ Congestive Heart Failure: Low sodium, low fat diet. Eat foods rich in potassium such as bananas and raisins. Drink orange juice and other citrus juices.

□ FOOD / DRUG INTERACTION EDUCATION PROVIDED

ACTIVITY: □ No restrictions / As tolerated  □ Return to work / school
□ No driving for _______ days / weeks

□ Follow up appointment with Dr. _________ on _________ at _________.
□ Please make a follow up appointment with Dr. _______ in _____ weeks

□ CONGESTIVE HEART FAILURE: Signs & symptoms to watch for
• Shortness of breath with light activity or shortness of breath at night when lying down flat.
• Puffiness or swelling of your feet, ankles, hands or eyes. Feeling bloated in belly.
• A constant dry cough or a productive cough with pinkish sputum.
• Weigh yourself each morning after you empty your bladder. Call your physician if your weight increases more than 3 pounds in 2 days.
• If any of the above symptoms worsen, notify your physician immediately.

□ WOUND CARE

□ SPECIAL INSTRUCTIONS

□ Medication Safety Information
• Take all medications exactly as prescribed and do not skip doses.
• Be aware of foods that could interact with your meds.
• Do not share your medications with other people.
• Check with your pharmacist before taking over-the-counter medications or herbal supplements that could interact with other medications.
• Do not use alcohol or operate machinery if on sedating medications such as pain medications.

□ Other

Referral

Pt. Name
□ See your private physician in _______ days □ if symptoms persist or worsen
□ See Doctor in _______ days
□ Telephone No.

Activity / Work Release

Pt. Name

No PE / Sports until

Return to work / school

Return to work with restrictions

Note: If you are unable to see your physician in the suggested period of time or feel your condition persists or worsens, please return to the Emergency Department.

My signature indicates that I have received the instructions, verbalized that I understand them, and am able to manage my continuing care after discharge. If I have been referred to a physician for continued medical care then I will do so. I am leaving with all of my personal belongings and valuables.

Signed / Relationship to Patient

Date

Designated Driver

Nurse / Physician

Rev. 10/05