DISCHARGE ORDERS

ACTIVITY: □ NO RESTRICTIONS □ RESTRICTIONS

MEDICATIONS: Ejection Fraction: ________ % (CHF Patients only)

Ace Inhibitor: __________________________
Beta Blocker: ____________________________

TREATMENT / PAIN MANAGEMENT:

CALL YOUR DOCTOR IF YOU HAVE:

DIET:

REGULAR ** ** CALORIE ADA ** ** Copy of diet given, as ordered by Physician
SOFT ** ** LOW SODIUM ** ** OTHER

FOLLOW UP REFERRALS:

Patient Education Booklet: ____________________________
Home Care: ____________________________
Return to MD: ____________________________
Other: ____________________________

EQUIPMENT: Supplies can be bought at: ____________________________

I HAVE RECEIVED THE ABOVE INSTRUCTIONS AND WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS

Discharging Physician’s Signature ____________________________ Date ____________________________

Physician’s Phone ____________________________ Patient / Responsible Person’s Signature ____________________________

Discharging Nurse’s Signature / Title ____________________________

WHITE = Chart  YELLOW = Patient  PINK = Physician

PART OF THE MEDICAL RECORD