DRAFT

29 June 2011 11:45 AM

PATIENT NAME Doe, Jane

DATE OF BIRTH 06.30.1965

MR# 897325210

My Info

Patient Name: ________ Date of Birth: __/__/__

Street Address: ________

City: ________ State: ________

Zip Code: ________ Home Phone: ( ) -

Emergency Contact Name: ________

Emergency Contact Phone: ( ) -

About My Stay

Admitted on: __/__/__ Discharged on: __/__/__

Reason for My Stay (Discharge Diagnoses):

1

2

3

4

Procedures during My Stay: Dates:

1 __/__/__

2 __/__/__

3 __/__/__

4 __/__/__

5 __/__/__

6 __/__/__

Problem List: Dates (if applicable):

1

2

3

4

5

6

7

8

9

10

Restricted Activities

Include weight bearing (partial or full), lifting limits, ability to shower, when to return to work/school/gym. **Also include duration of restrictions**.

? Physician to Call with Questions About My Care

Physician: ________

Phone: ( ) -

Call physician if following occurs: ________

My Doctor's Orders

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Respiratory Therapy
- ☐ Speech Therapy
- ☐ Home Care Evaluation
- ☐ Skilled Nursing

Diet: ________

Wound Care: ________

My Follow-Up

Follow-Up Physician: ________

Phone: ( ) - Physician Notified: ☐ Yes ☐ No

Follow-Up Appointments: Date:

1 Physician: ________ __/__/__
Phone: ( ) - ☐ Patient chooses to make own appointment.

2 Physician: ________ __/__/__
Phone: ( ) - ☐ Patient chooses to make own appointment.

3 Physician: ________ __/__/__
Phone: ( ) - ☐ Patient chooses to make own appointment.

Physician during Admission

Physician: ________

Phone: ( ) -

All pages of this form must be completed.

Rhode Island Department of Health

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Advance Directives (During This Stay)

(Attach Form) ☐ None ☐ DNR (Do Not Resuscitate) ☐ CMO (Comfort Measures Only) ☐ DNI (Do Not Intubate) ☐ DNH (Do Not Hospitalize)

Labs

Pertinent Lab / Studies, Results — Dates:

1 ____ / /
2 ____ / /
3 ____ / /
4 ____ / /
5 ____ / /
6 ____ / /

Pending Lab/Studies, Results — Contact # for Results: ( ) -

1
2
3
4
5

IF ON COUMADIN → Goal INR Value: –

Last INR: Date: / / Dose: Value:

Next INR: Date: / / Dose:

Consultants

1 Physician: ☐ Inpatient
Specialty: Phone: ( ) - ☐ Outpatient

2 Physician: ☐ Inpatient
Specialty: Phone: ( ) - ☐ Outpatient

3 Physician: ☐ Inpatient
Specialty: Phone: ( ) - ☐ Outpatient

4 Physician: ☐ Inpatient
Specialty: Phone: ( ) - ☐ Outpatient

CMS Face to Face Encounter

☐ Physical Therapy ☐ Speech Therapy ☐ Skilled Nursing

Primary diagnosis and reason for home health care services:

Findings supporting patient's homebound status:

Vital Signs at Discharge

Date: / / Time: ☐ am ☐ pm

Height: Weight: ☐ lb ☐ kg

Temp: ☐°F ☐°C Resp.: /m

Pulse: /min Blood Pressure: mmHg

Pulse Oximeter: % on RA / Oxygen @ LPM

Pain Score

Date: / / Time: ☐ am ☐ pm

Circle One:

0 1 2 3 4 **5** 6 7 8 9 **10**

No Pain — Moderate — Severe

Describe Pain:

Immunizations

Immunizations this Admission: — Date:

☐ Influenza / /
☐ Pneumovax / /
☐ Tetanus / /
☐ Other: / /

Information Given to Patient

☐ Written Information on Medications
☐ Pain Management Instructions
☐ Diet Instructions
☐ Diabetes Education Material
☐ Food/Drug Interactions
☐ Drug/Drug Interactions
☐ Asthma Management Plan
☐ CHF Brochure (Including Diet and Weight)
☐ Comfort One Band

Has patient smoked in the past 12 months?

☐ No ☐ Yes → ☐ Written instructions on smoking cessation

Patient Discharge Location

☐ Home - No Services
☐ Rehab
☐ Nursing Home
☐ Assisted Living Facility
☐ Home Care Services
☐ Other:

Name:

Phone: ( ) -

Attending Physician Signaure: (Signing for Pages 1-5, including addenda and Face to Face Encounter)

Signature: Today's Date: / /

Printed Name: Date of Last MD Encounter: / /

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Communication

Primary Language:______________________________
Able to: ☐ Understand ☐ Speak ☐ Read ☐ Write

Secondary Language:______________________________
Able to: ☐ Understand ☐ Speak ☐ Read ☐ Write

☐ Sign Language
☐ Aphasia ⟶ ☐ Receptive ☐ Expressive
☐ Dysarthria

Cognitive Status

How well does the patient make decisions about organizing the day? (Choose one.)

☐ Independent
☐ Modified Independence - some difficulty in a new situation
☐ Moderately Impaired - decisions poor, cues / supervision needed
☐ Severely Impaired - never or rarely decides

Level of consciousness? (Choose one.)

☐ Alert
☐ Drowsy, but aroused with minor stimulation
☐ Requires repeated stimulation to respond
☐ Responds only with reflex motor and autonomic system
☐ Effects or totally unresponsive

Patient is oriented to:

☐ Person ☐ Place ☐ Year

☐ Thought or speech organization is coherent
☐ Maintains attention, not easily distracted
☐ Short term memory intact - recalls 3 items after 5 minutes

Impairments

Auditory

☐ Hears Adequately
☐ Minimal Difficulty
☐ Intermittently Impaired
☐ Highly Impaired

☐ Has hearing aid
☐ Has cochlear implant
☐ Does not wear hearing assistive device
☐ Recommend assistive device for effective communication

Vision (with glasses, if used):

☐ Sees adequately
☐ Impaired- sees large print but not regular print
☐ Moderately impaired- limited vision cannot see headlines
☐ Severely impaired - no vision or only sees light, color, shapes

☐ Uses visual device (Type): ______________

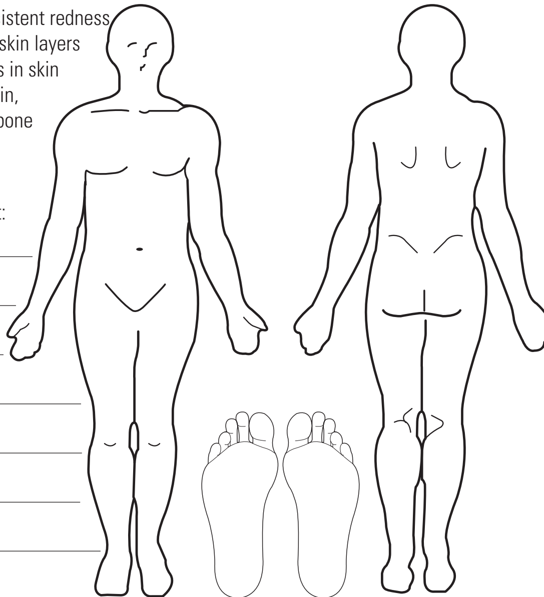
Pressure Ulcers

Stage and location on diagram of all decubitis ulcers.

1= (Stage 1) area of persistent redness
2= (Stage 2) partial loss skin layers
3= (Stage 3) deep craters in skin
4= (Stage 4) breaks in skin, exposed muscle and/or bone
5= Unstageable

☐ Other wounds present:

____
____
____
____
____
____
____
____



Active Infections

Infection control precautions: ☐ Yes ☐ No

	Positive Screen	Active Infection	Date Resolved	Test Pending
MRSA				☐
VRE				☐
				☐
TB Status	Neg	Pos	Unknown	☐
				☐

Activities of Daily Living

On discharge day.

Codes:

0= Independent
1= Supervision
2= Limited Assistance
3= Extensive Assistance
4= Total Dependance
5= Activity did not occur

______Transfer
______Dressing
______Toileting
______Personal Hygiene
______Walking
______Eating
______Bathing

Mobility

Circle all that apply.	Patient's Left		Patient's Right	
Upper Extremities	Normal	Impaired	Normal	Impaired
Lower Extremities	Normal	Impaired	Normal	Impaired

☐ Amputee:______________________________
☐ Prosthesis Use:______________________________

Equipment needed on discharge:
☐ Cane ☐ Wheelchair ☐ Walker ☐ Other:

Bowel & Bladder Assessment

☐ Dialysis (type):______________________________
Date of Last Session: ___/___/___
☐ Foley (type):______________________________ Size:________
Date Changed:___/___/___
☐ Ostomy (type):______________________ Balloon Size: ________
Date of last BM:______________

Bladder: ☐ Continent ☐ Occasionally Incontinent ☐ Frequently Incontinent ☐ Incontinent

Bowel: ☐ Continent ☐ Occasionally Incontinent ☐ Frequently Incontinent ☐ Incontinent

Respiratory Orders

☐ Trach. Size/Type:______________ Placed on:___/___/___

☐ Nasal Cannula ☐ CPAP ☐ BiPAP
Settings:______________________ O_2 Rate: __________

☐ Ventilator: Mode:________ Rate:________
Volume:________ Pressure:________
PEEP:________ FiO2:________

☐ Resp. Care: ______________________________

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Hospital Course

Chief Complaint:

History of Present Illness:

☐ Refer to attached History & Physical

! See page 1 for discharge diagnosis, procedures, and problem list.

Patient Discharge

Discharge Plan:

Condition Upon Discharge Including Wounds:

Brief Narrative of Hospital Stay

☐ Refer to attached D/C Summary

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Allergies

Allergies (with reactions): ☐ No Known Drug Allergies

____

____

My Medication List

Date Completed: ___/___/___

Note: Nursing homes require prescriptions for Schedule II medications.

Continue Taking These Medications	Dose	Route	Frequency	Time Last Given	Time Next Dose	! New Dose	! New Medication
1						☐	☐
2						☐	☐
3						☐	☐
4						☐	☐
5						☐	☐
6						☐	☐
7						☐	☐
8						☐	☐
9						☐	☐
10						☐	☐
11						☐	☐
12						☐	☐
13						☐	☐
14						☐	☐
15						☐	☐
16						☐	☐
17						☐	☐
18						☐	☐
19						☐	☐
20						☐	☐
21						☐	☐
22						☐	☐
23						☐	☐
24						☐	☐
25						☐	☐
26						☐	☐
27						☐	☐

STOP Taking These Medications
1
2
3
4
5

Explanation of any changes to medications or treatments: ______________________________

I understand these instructions and have received a copy of pages 1 & 5:

Patient Signature:	Date: / /	Nurse Signature:	Date: / /

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Additional Information

Choose One:

- ☐ Problem List (Cont.)
- ☐ Discharge Diagnosis (Cont.)
- ☐ Procedures (Cont.)
- ☐ Hospital Course (Cont.)
- ☐ ______________________________

Additional Information

Choose One:

- ☐ Problem List (Cont.)
- ☐ Discharge Diagnosis (Cont.)
- ☐ Procedures (Cont.)
- ☐ Hospital Course (Cont.)
- ☐ ______________________________