



PATIENT DISCHARGE. NOTIFICATION/INSTRUCTIONS
ALTA DEL PACIENTE. NOTIFICACION/INTRUCCIONES

Discharge Date/Fecha de Alta del Paciente _____

Patient Name/Nombre de el(la) Paciente _____

Patient Record Number/Número de Record del Paciente _____

Dear Patient/Estimado Paciente:

It has been our pleasure to assist you during your recovery period from your recent illness, in accordance with your private physician's plan of treatment and in compliance with Medicare/Medicaid guidelines, you are being discharged from all home health services.

Ha sido un placer asistirlo durante su periodo de recuperación de su reciente enfermedad. De acuerdo con el plan de tratamiento de su médico y en cumplimiento de las regulaciones de Medicare/Medicaid, Ud. está siendo dado de alta de sus servicios de cuidado a la casa.

1.-Continue to follow any Diet instructions you received/Continúe las Instrucciones de Dieta Recibidas.

Current Diet/Dieta Corriente _____

2.-Take Only Medications Prescribed by Your Doctor, Discard all Out-Dated Medications/Tome Solamente Medicamentos Recetados por su Doctor, Deseche Todos los Medicamentos Expirados.

Current Medications Include/Medicamentos Actuales Incluyen: See current/updated medication schedule/Vea el listado de medicamentos actualizado
Comment/Comentarios: _____

3.-Continue with the Following Treatments/Continue con los Sigüientes Tratamientos:

Current Treatments Include/Tratamientos Actuales Incluyen _____

4.-Continue with the Following Activities/Continue con las Sigüientes Actividades:

Current Activities Include/Actividades Actuales Incluyen _____

Special Precautions/Precauciones Especiales _____

Psychosocial Need Follow/Necesidades Psicosociales a Seguir _____

Community Resource to Contact-Referrals Made/Recursos de la Comunidad para Contactar o Referir _____

Keep Doctor's Name and Phone Number, and Your Address Clearly Printed Next to Your Phone or On Your Refrigerator. Keep Name and Phone Number of Friend or Relative to Be Contacted in Case of Emergency, Next to Your Phone or On Your Refrigerator.

Mantenga Nombre y Teléfono de Su Médico, así como su dirección, claramente escritos Cerca de Su Teléfono o Refrigerador. Mantenga Nombre y Teléfono de un Amigo o Familiar que Pueda Ser Contactado en Caso de Emergencia

Physician Name/Nombre del Médico _____

Phone Number/Número de Teléfono _____

Next Physician Appointment/Próxima Cita _____

Instructions given to/Instrucciones dadas a _____

Relationship to Patient/Relación con el Paciente _____

Patient signature / Firma del Paciente

Date/Fecha

Witness (Agency's Representative)/Testigo(Representante de la Agencia.)

Date/Fecha



PATIENT DISCHARGE INSTRUCTIONS

PATIENT NAME _____ D/C DATE _____

DIET _____

MEDICATIONS _____

TREATMENTS _____

SPECIAL PRECAUTIONS _____

ACTIVITY _____

WHEN TO CALL THE PHYSICIAN _____

SAFETY/DISASTER PLAN _____ **FOR EMERGENCY CALL 911**

COMMUNITY RESOURCES AVAILABLE TO HELP YOU _____

IMPORTANT PHONE NUMBERS

PHYSICIAN _____ PH. _____ NEXT APPT _____

PHARMACY _____ EQUIP _____ OTHER _____

INSTRUCTION GIVEN TO _____

PROFESSIONAL SIGNATURE/TITLE _____ DATE _____

FOR RECURRING HOME CARE NEEDS OR QUESTIONS, CALL _____

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOU.



DISCHARGE INSTRUCTIONS
INSTRUCCIONES AL DARLE DE ALTA

Date of Discharge (Fecha de Alta) ____/____/____

We are pleased to have provided service to you. The following discharge instructions were reviewed with you and/or your caregiver(s) during the final visit(s) by organization staff. You are to:

Nos agradó haberle proveído servicios. Las siguientes instrucciones fueron revisadas con usted o su guardian:

Keep your scheduled appointment with Dr. /Mantenga sus visitas al Dr. _____

Day/Día _____ Date (Fecha) ____/____/____ Time (Hora) _____

Continue to take medications as prescribed by your physician. (tome las medicinas como le indicaron)

Instructions attached (vea las instrucciones adjuntas)

Additional comments/instructions: (Instrucciones adicionales) _____

Continue with home program as instructed by therapist. (Continúe con el programa indicado por el terapeuta)

Instructions attached (vea las instrucciones adjuntas)

Additional comments/instructions: (Instrucciones adicionales) _____

Follow the diet as prescribed by your physician and instructed by your nurse/dietitian. (siga la Dieta prescrita)

Continue with skin/wound care as instructed by your nurse. (continúe cuidando su piel/herida)

Instructions attached (vea las instrucciones adjuntas)

Additional comments/instructions: (Instrucciones adicionales) _____

Follow through with community resource or other organization to which you have been referred (describe):

Siga con el servicio de los recursos de la comunidad u organización al cual fue referido:

Other instructions (describe): (Otras instrucciones) _____

If you have questions concerning these instructions, please call your care manager at (Si tiene preguntas llámenos) (____) _____. We hope that if you have need for home care in the future; you will contact us. Esperamos que si tiene necesidad de cuidado de la salud a domicilio en el futuro nos llame.

Care Manager Signature/Title _____ Date ____/____/____

PART 1 – Clinical Record

PART 2 – Patient/Client

PATIENT/CLIENT NAME – Last, First, Middle Initial

ID#



Discharge Instruction Sheet/*Instrucciones Al Darlo De Alta*

Patient Name: _____ MR# _____
Nombre del Paciente

Physician's Name: _____ TELEPHONE: _____
Nombre del Médico *Teléfono*

Date of Discharge _____ Receiving Facility: _____
Fecha de Alta *Facilidad de traslado*

Medications to be Continued/*Medicinas Que Debe Seguir Tomando*

Name of Medication <i>Medicinas</i>	Meds Schedule <i>Horario</i>	Possible Side Effects <i>Efectos posibles</i>	TX Given <i>Tratamiento</i>

Activities/*Actividades*

Wound Care/*Cuidado de heridas/úlceras*

Diet Instructions/*Intruciones para la Dieta*

Special Instructions/*Instrucciones Especiales*

Nursing Signature/*Firma Enfermera*: _____ Date/*Fecha*: _____



GENTLE CARE Inc.

DISCHARGE SUMMARY

Patient: _____ MR#: _____
Start of Care Date: _____ D/C Date: _____
Physician notified of Discharge: ___ YES ___ NO., Reason: _____
Primary Diagnosis: _____
Status on Admission: _____

Services Provided: ___ SN ___ HHA ___ MSW ___ Other(specify) _____

Status Upon Discharge:

Goals: Status upon Discharge
#1: _____ Met ___ Not Met ___ Partially Met
#2: _____ Met ___ Not Met ___ Partially Met
#3: _____ Met ___ Not Met ___ Partially Met
#4: _____ Met ___ Not Met ___ Partially Met

Reason Goal(s) partially/not met: _____

Instructions provided:

___ Safety/Emergency Procedures ___ Disease process
___ Meds: Actions/S/E; specifically: _____
___ S/S of Complications requiring medical attention
Patient/care giver response to teaching: _____

Condition/Status upon D/C: ___ Stable ___ Unstable ___ Expired
Psychosocial status at D/C: ___ Oriented ___ Disoriented ___ Forgetful ___ Alert
___ Alert ___ Depressed ___ Agitated ___ Lethargic
___ Judgement: ___ Good ___ Fair ___ Poor
___ Perception: ___ Good ___ Fair ___ Poor

Adjustment to illness/disability: ___ Yes ___ No: Comments. _____

Support system: _____

Community Referrals: ___ No ___ Yes; specify: _____

Signature/Title of Person Completing form _____ Date _____

cc: ___ Physician ___ Other: _____



MEDICARE DISCHARGE CHART AUDIT FORM

PATIENT NAME:		MR#			
DOCUMENT	YES	NO	N/A	FIXED	COMMENTS
REFERRAL COMPLETE					
AGREEMENT (SIGNED/DATED)					
EMERGENCY PLAN (COMPLETED)					
MSP SIGNED/ DATED					
MECCA					
POC (SIGNED/DATED/RETURNED)					
MOD SIGNED/DATED					
MED UPDATE SIGNED QMOD/QMONTH					
MIED SHEET SIGNED/DATED					
NURSES NOTES SIGNED					
SOC OASIS COMPLETED					
TRANSFER OASIS					
RESUMPTION OF CARE OASIS					
HHA NOTES COMPLETED/SIGNED					
HHA CARE PLAN					
SUPERVISORY VISIT					
PHYSICAL THERAPY EVAL/OASIS					
PHYSICAL THERAPY NOTES					
PHYSICAL THERAPY DISCHARGE					
OASIS DISCHARGE					

1 - SIGNATURE DATE OF AUDIT

2. SIGNATURE/DATE OF AUDIT

3. SIGNATURE/DATE OF AUDIT



NURSING DISCHARGE SUMMARY AND NOTE

<input type="checkbox"/>	Visit Made
<input type="checkbox"/>	No Visit

Patient: _____ To: Dr. _____
 ID #- _____ HIC#: _____ Address: _____
 SOC: _____ First Visit: _____ City: _____ Zip: _____
 D/C Date: _____ Complete or Partial - Continued Service _____
 Reason for Discharge: _____
 Number of Visits: SN: _____ AIDE: _____ PT: _____ OT: _____ SLP: _____ MSS: _____ NUTR: _____
 Diagnosis: _____

**IF NO VISIT IS MADE, DOCUMENT LAST S/N ASSESSMENT VISIT FINDINGS:
 DISCHARGE ASSESSMENT STATUS**

T: _____ P: _____ R: _____ B/P: _____
 Mental/Emotional: _____ Skin: _____
 EENT: _____ Cardiac: _____
 Edema: _____ Respiratory: _____
 GI: _____ GU: _____
 Nutritional: _____ Neuro: _____
 Musculoskeletal: _____ Mobility: _____ Level: _____
 Knowledge of level of: _____
 Disease Process: _____ Medicine Schedule: _____
 Medication S/E + actions: _____ Treatments: _____
 Care Management: _____ Safety: _____
 Other: _____

Reason for Admission: _____

Summary of Care Provided: _____

Condition at Discharge: _____

NEW PROBLEMS IDENTIFIED AFTER START OF CARE: _____

SELF CARE ACTIVITY ON ADMISSION: _____

At D/C: Self care resumed or Assist to be provided by _____ or Transferred to _____

CARE PROVIDED: Observation/Evaluation Instruction Personal Care as Ordered Treatments as needed
 Other _____

GOALS MET: Yes No If no explain why _____

INSTRUCTIONS FOR CONTINUING CARE NEEDS: Physician Follow-up Medication Biomedical Waste
 Equipment Other _____

ADDITIONAL COMMENTS/Referrals Made: _____

Physician contacted on _____ and discharged is approved.

RN Signature: _____ Date: _____



4960 SW 72nd Ave. Suite 302
 Miami, Fl. 33155
 Office: 786-268-4320
 Fax: 786-268-4311

Physician Name: _____
 Physician Address: _____

 Physician Phone: _____

DISCHARGE ORDER

Patient Name: _____ MR #: _____
 Patient Address: _____
 Diagnosis: _____
 Date Effective: _____

DISCHARGE PATIENT FROM HOME HEALTH SERVICES TODAY

DISCHARGE THE FOLLOWING DISCIPLINE AND PATIENT WILL CONTINUE WITH HOME HEALTH SERVICES

Skilled Nurse Aide Physical Therapy Occupational Therapy
 Speech Therapy Medical Social Worker Respiratory Therapy

REASON FOR DISCHARGE

Goals Met Patient Refused Further Services Patient has moved out of geographical area
 Patient has expired Hospitalization Physician Cancelled Services
 Transferred to Another Agency Partial Discharge Other

 Signature of Nurse Receiving Orders

 Date

 Physician Signature

 Date

Date Received: _____

www.pmsystem.com
 305.878.5940



NURSING DISCHARGE SUMMARY / NOTE

PATIENT _____ MED REC # _____ ADM DATE _____ DISCH DATE _____ DIAGNOSIS (Primary) _____	DR. _____ ADDRESS _____ CITY, ZIP _____ TEL _____
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SERVICES RENDERED: <i>Frequency on ADM to Discharge</i> SN _____ H H A _____ MSW _____ <input type="checkbox"/> DIETICIAN	REASON FOR DISCHARGE: _____ <input type="checkbox"/> PARTIAL - STILL RECEIVING SERVICES OF: <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> HHA <input type="checkbox"/> COMPLETE
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CONDITION ON DISCHARGE: <input type="checkbox"/> STABLE <input type="checkbox"/> IMPROVED <input type="checkbox"/> UNSTABLE <input type="checkbox"/> DECEASED	DISPOSITION OF THE PATIENT: <input type="checkbox"/> ABLE TO CARE FOR SELF <input type="checkbox"/> INSTITUTIONALIZED	<input type="checkbox"/> FAMILY TO ASSIST <input type="checkbox"/> HOMEMAKER TO ASSIST <input type="checkbox"/> DECEASED
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LAST M.D. VISIT: _____ LAB REPORTS _____	RN CONTACTED PHYSICIAN ON DATE: _____ AND DISCHARGE IS APPROVED. SUMMARIZE: _____ CHANGE ORDERS / NEW DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO
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SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

<input type="checkbox"/> VERBALIZES KNOWLEDGE OF MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET, FLUIDS, DISEASE PROCESS, TREATMENT PROGRAM. <input type="checkbox"/> S/S NECESSITATING MEDICAL ATTENTION. <input type="checkbox"/> RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS. <input type="checkbox"/> HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.	<input type="checkbox"/> PRESENTING SYMPTOMS ABSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION. <input type="checkbox"/> INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS. <input type="checkbox"/> MAXIMUM POTENTIAL OF SKILLED SERVICES ATTAINED WITHIN HOME SETTING.
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SKILLED OBSERVATION / ASSESSMENT ON DISCHARGE

DISCHARGED V/S _____ VITAL SIGNS RANGE: BP _____ TO _____ AP _____ TO _____ RR _____ TO _____ TEMP _____ TO _____	MENTAL STATUS: <input type="checkbox"/> ALERT <input type="checkbox"/> DISORIENTED <input type="checkbox"/> FORGETFUL <input type="checkbox"/> CONFUSED <input type="checkbox"/> ANXIOUS DERMA: TURGOR <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR WOUND/DECUBITUS: <input type="checkbox"/> HEALED <input type="checkbox"/> NOT HEALED-PT/FAMILY DEMONSTRATES PROPER WOUND CARE	CARDIAC/CIRCULATORY: <input type="checkbox"/> FREQUENCY OF CHEST PAIN <input type="checkbox"/> FREE OF CHEST PAIN <input type="checkbox"/> CONTROLLED ON MEDICATION EDEMA: <input type="checkbox"/> NONE <input type="checkbox"/> TRACE <input type="checkbox"/> MILD <input type="checkbox"/> PITTING <input type="checkbox"/> NON-PITTING NUTRITION: DIET _____ <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> TPN APPETITE: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	PULMONARY: LUNGS: <input type="checkbox"/> CLEAR <input type="checkbox"/> RONCHI <input type="checkbox"/> IBS <input type="checkbox"/> RALES <input type="checkbox"/> WHEEZING <input type="checkbox"/> O2 <input type="checkbox"/> REQUIRED <input type="checkbox"/> NOT REQUIRED ENDOCRINE: DIABETES <input type="checkbox"/> DIET CONTROLLED <input type="checkbox"/> ORAL HYPOGLYCEMIC <input type="checkbox"/> INSULIN DEPENDENT EENT: HEARING <input type="checkbox"/> GOOD <input type="checkbox"/> POOR VISION <input type="checkbox"/> GOOD <input type="checkbox"/> POOR
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<input type="checkbox"/> POST CATARACT CARE <input type="checkbox"/> INJECTION ADMINISTRATION <input type="checkbox"/> DISEASE PROCESS <input type="checkbox"/> S/S OF COMPLICATIONS <input type="checkbox"/> ACTION/SIDE EFFECTS OF MEDS <input type="checkbox"/> FOLEY CARE <input type="checkbox"/> WOUND/DECUBITUS CARE	PATIENT / FAMILY INSTRUCTED IN: <input type="checkbox"/> CARE OF TERMINALLY ILL <input type="checkbox"/> DIABETIC MANAGEMENT <input type="checkbox"/> DIET/FLUID INTAKE <input type="checkbox"/> OSTOMY/CONDUIT CARE <input type="checkbox"/> SAFETY FACTORS	<input type="checkbox"/> ACTIVITY RESTRICTIONS <input type="checkbox"/> ADMINISTRATION OF TUBE FEEDINGS <input type="checkbox"/> ADMINISTRATION OF INHALATION RX <input type="checkbox"/> IV THERAPY <input type="checkbox"/> FIT. INDWELLING CATHETER CARE/PRECAUT. <input type="checkbox"/> S/S COMPLICATIONS/INFECTION
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PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: GOOD FAIR POOR REPETITIVE TEACHING REQUIRED

NURSING GOALS MET: YES NO IF NO, EXPLAIN _____

PATIENT/FAMILY GOALS MET: YES NO ... IF NO, EXPLAIN _____

ADDITIONAL COMMENTS AND INSTRUCTIONS: _____

RN SIGNATURE _____ DATE _____

SALUD HOME CARE

DISCHARGE IN OFFICE/AGENCY

Patient's Name: _____ MR #: _____

Date of Discharge: _____ Report date to MD: _____

Other Patient identifying information (Medicare, Medicaid, Insurance): _____

Patient's physician and phone number: _____

Patient's Status at Discharge: _____

Name/Title of person making report: _____

Primary Diagnosis: _____

Reason for Discharge: Dead at Home Move out from area of services: _____

Transfer to an in-patient facility: _____

Other, explain: _____

A brief description of why was unable to complete the discharge assessment (OASIS, if applicable), services provided and ongoing needs that were not met::

Signature & Title of Staff making report

Date

Copy faxed to Patient's Physician

OT DISCHARGE/TRANSFER SUMMARY

PATIENT NAME _____ Admission Date: ____/____/____ Discharge Date: ____/____/____ Date of Last Billable Visit: ____/____/____ Diagnosis (Primary) _____	DR. _____ Address: _____ _____ Tel. No. (____) _____
SERVICES RENDERED: Total # of actual visits RN _____ HHA _____ PT _____ OT/ST _____ MSW _____ Other _____	REASON FOR DISCHARGE _____ <input type="checkbox"/> Partial - still receiving services of RN, PT, ST, OT, HHA <input type="checkbox"/> Complete

CONDITION ON DISCHARGE: <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Unstable <input type="checkbox"/> Deceased	DISPOSITION OF THE PATIENT: <input type="checkbox"/> Able to care for self <input type="checkbox"/> Family to assist <input type="checkbox"/> Institutionalized <input type="checkbox"/> Homemaker to assist <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____
--	--

RN/PT/OT/ST contacted physician on ____/____/____ and discharged is approved.

SUMMARIES:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:	
<input type="checkbox"/> Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention. <input type="checkbox"/> Return to previous lifestyle with modification within disease limitations. <input type="checkbox"/> Independence in self care within disease limitation	<input type="checkbox"/> Home free of hazards using proper safety <input type="checkbox"/> Presenting symptoms absent and/or controlled by appropriate intervention <input type="checkbox"/> Maximum potential attained within home setting.

On Discharge: _____ _____ _____/____	VITAL SIGNS TEMPERATURE PULSE RESPIRATION BLOOD PRESSURE	Vital Signs Range _____ TO _____ _____ TO _____ _____ TO _____ ____/____ TO ____/____
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PATIENT/FAMILY INSTRUCTED IN:		
<input type="checkbox"/> Post cataract care <input type="checkbox"/> Injection Administration <input type="checkbox"/> Disease Process <input type="checkbox"/> S/S of complications <input type="checkbox"/> Action/Side effects of Medications	<input type="checkbox"/> Wound/Decubitus Care <input type="checkbox"/> Diabetic Management <input type="checkbox"/> Diet/Fluid Intake <input type="checkbox"/> Ostomy/Conduit Care <input type="checkbox"/> Safety Factors <input type="checkbox"/> Foley Care	<input type="checkbox"/> Activity Restrictions <input type="checkbox"/> Administration of Tube Feedings <input type="checkbox"/> Administration of Inhalation Rx <input type="checkbox"/> IV Therapy <input type="checkbox"/> Indwelling Catheter Care/Precaut. <input type="checkbox"/> S/S Complications/Infection

Patient/Family response and adherence to teachings: Good Fair Poor Repetitive teaching required

Goals Met: Yes No If No, explain _____

Patient/Family Goals Met: Yes No If No, explain _____

Employee's Signature: _____ Title _____ Date ____/____/____



THERAPY DISCHARGE SUMMARY / NOTE

PATIENT _____ DR. _____
 MED REC. # _____ ADM DATE _____ DISCH DATE _____ ADDRESS _____
 DIAGNOSIS: (PRIMARY) _____ CITY, ZIP _____ TEL. _____

SERVICES RENDERED: And # of visits per discipline

RN HHA MSW P.T. ST O.T.

REASON FOR DISCHARGE

- | | |
|--|---|
| <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Skill Nursing |
| <input type="checkbox"/> Moved From Area | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Refuse | <input type="checkbox"/> Rehabilitated To Potential |

CONDITION ON DISCHARGE:

- STABLE UNSTABLE DECEASED

DISPOSITION OF THE PATIENT:

- ABLE TO CARE FOR SELF FAMILY TO ASSIST BOARDING HOME/ACLF

PHYSICIAN CONTACTED ON DATE: _____ AND DISCHARGE IS APPROVED

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

- | | |
|---|---|
| <input type="checkbox"/> VERBALIZES KNOWLEDGE OF DISEASE PROCESS. TREATMENT PROGRAM, S/S NECESSITATING MEDICAL ATTENTION. | <input type="checkbox"/> ADMITTING SYMPTOMS ASSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION. |
| <input type="checkbox"/> RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS. | <input type="checkbox"/> INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS |
| <input type="checkbox"/> HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES. | <input type="checkbox"/> MAXIMUM POTENTIAL ATTAINED WITHIN HOME SETTING. |

SKILLED OBSERVATION / ASSESSMENT ON DISCHARGE**MENTAL STATUS**

- ALERT DISORIENTED
 FORGETFUL CONFUSED
 ANXIOUS

Current Functional Limitations: Code I - Independent, A - Assistance, U - Unable.

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Supine To Sit | <input type="checkbox"/> Sitting Balance | <input type="checkbox"/> Sit To Read | <input type="checkbox"/> Standing Balance | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Transfers: | <input type="checkbox"/> Balance to Chair | <input type="checkbox"/> Chair To Toilet | <input type="checkbox"/> Chair To Car | <input type="checkbox"/> Chair To Bathtub |
| <input type="checkbox"/> Ambulation On: | <input type="checkbox"/> Levels <input type="checkbox"/> Stairs | <input type="checkbox"/> Ramp | | |

Ft: _____ Device: _____

PATIENT / FAMILY INSTRUCTED IN:

- | | |
|---|--|
| <input type="checkbox"/> DISEASE PROCESS | <input type="checkbox"/> ACTIVITY RESTRICTIONS |
| <input type="checkbox"/> S/S OF COMPLICATIONS | <input type="checkbox"/> S/S COMPLICATIONS |
| <input type="checkbox"/> HEP | <input type="checkbox"/> SAFETY FACTORS |

PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: GOOD FAIR POOR REPETITIVE TEACHING REQUIRED

THERAPY: GOALS MET: YES NO ... IF NO, EXPLAIN _____

Patient/Family GOALS MET: YES NO ... IF NO, EXPLAIN _____

ADDITIONAL COMMENTS AND INSTRUCTIONS: _____

THERAPIST PRINT NAME/TITLE: _____

THERAPIST SIGNATURE/TITLE: _____



THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME FIRST NAME PATIENT #

TYPE OF DISCHARGE: COMPLETE PARTIAL - STILL RECEIVING SERVICES OF: PT ST OT HHA SN

ADM DATE DISCH DATE DR

DIAGNOSIS (PRIMARY) ADDRESS
 CITY, ST ZIP

VISITS RENDERED BY: RN HHA PT OT ST Msw

REASON FOR DISCHARGE: GOALS MET MOVED OUT OF AREA OTHER
 HOSPITALIZATION PATIENT EXPIRED
 SKILLED NURSING FACILITY CARE REFUSED
 TRANSFER TO ANOTHER AGENCY SKILLED CARE NO LONGER NEEDED

DISPOSITION SELF CARE NH ACLF FAMILY CARE OTHER

CONDITION IMPROVED STABLE UNSTABLE DECEASED REGRESSED

DEPENDENCY DEPENDENT INDEPENDENT REQUIRES SUPERVISION/ASSIST

EXERCISES PASSIVE ACTIVE ACTIVE ASSISTIVE RESISTIVE

PERFORMED WITH: R.U.E. R.L.E. L.U.E. L.L.E. TRUNK NECK

TRANSFER HOYER LIFT CRUTCHES WALKER

ACTIVITIES: W/C CANE QUAD CANE OTHER

GAIT TRAINING: N.W.B. P.W.B. F.W.B.

EVEN SURFACES STAIRS UNEVEN SURFACES

ASSISTANCE REQUIRED: MAXIMUM MINIMUM MODERATE GUARDING OTHER

DISTANCE AMBULATED: 20 ft. 40 ft. 60 ft. 80 ft. 100 ft. 120 ft.

INSTRUCTED ON HOME PROGRAM: PATIENT SIGNIFICANT OTHER FAMILY

NARRATIVE:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

- PATIENT HAS ACHIEVED ANTICIPATED GOALS
- PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
- ABSENCE OF PAIN
- FREE OF CONTRACTURES
- RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
- DEMONSTRATES RANGE OF MOTION EXERCISES
- DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
- DEMONSTRATES TURNING AND POSITIONING SCHEDULE
- AMBULATES SAFELY WITH ASSISTIVE DEVICE
- AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

Speech Therapy

- PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
- VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

- DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
- DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
- HEALED INCISION
- DEMONSTRATES STUMP WRAPPING AND HYGIENE
- DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
- DESCRIBES PHANTOM LIMB SENSATION
- PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Occupational Therapy

- PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
- DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
- DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: GOOD FAIR POOR

THERAPY GOALS MET: YES NO IF NO, EXPLAIN

PATIENT/S.O. GOALS MET: YES NO IF NO, EXPLAIN

COMMENTS:

PATIENTS/SO. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE DATE

SPEECH THERAPY DISCHARGE/TRANSFER SUMMARY

PATIENT NAME _____ Admission Date: ____/____/____ Discharge Date: ____/____/____ Date of Last Billable Visit: ____/____/____ Diagnosis (Primary) _____	DR. _____ Address: _____ _____ Tel. No. (_____) _____
SERVICES RENDERED: Total # of actual visits SN _____ HHA _____ PT _____ OT _____ MSW _____ ST _____	REASON FOR DISCHARGE _____ <input type="checkbox"/> Partial - still receiving services of RN, PT, MSW, OT, HHA <input type="checkbox"/> Complete <input type="checkbox"/> Transfer to: _____

CONDITION ON DISCHARGE: ___ Stable ___ Improved ___ Unstable ___ Deceased	DISPOSITION OF THE PATIENT: ___ Able to care for self ___ Family to assist ___ Institutionalized ___ Homemaker to assist ___ Deceased ___ Other: _____
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Speech therapist contacted physician on ____/____/____ and discharged is approved.

SUMMARIES:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:	
___ Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention. ___ Return to previous lifestyle with modification within disease limitations. ___ Independence in self care within disease limitation	___ Home free of hazards using proper safety ___ Presenting symptoms absent and/or controlled by appropriate intervention ___ Maximum potential attained within home setting.

STATUS AT DISCHARGE: <input type="checkbox"/> Voice disorders: _____ <input type="checkbox"/> Speech articulation disorders: _____ <input type="checkbox"/> Dysphagia: _____ <input type="checkbox"/> S/S of complications: _____	<input type="checkbox"/> Language disorders: _____ <input type="checkbox"/> Aural rehabilitation: _____ <input type="checkbox"/> Non oral communication: _____ <input type="checkbox"/> Alaryngeal speech skills: _____	<input type="checkbox"/> Safe swallowing evaluation: _____ <input type="checkbox"/> Lip, tongue facial exercise: _____ <input type="checkbox"/> Pain management: _____ <input type="checkbox"/> Speech dysphagia: _____
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PATIENT/FAMILY INSTRUCTED IN:		
<input type="checkbox"/> Physician follow visits <input type="checkbox"/> Home lip, facial, tongue exercises program <input type="checkbox"/> Disease Process <input type="checkbox"/> S/S of complications <input type="checkbox"/> Action/Side effects of Medications	<input type="checkbox"/> Care of voice prosthesis <input type="checkbox"/> Develop communication system <input type="checkbox"/> Diet/Fluid Intake <input type="checkbox"/> Food texture recommendations <input type="checkbox"/> Safety Factors <input type="checkbox"/> Improve swallowing/vocal skills	<input type="checkbox"/> Activity Restrictions <input type="checkbox"/> Rehabilitation program <input type="checkbox"/> Home maintenance program <input type="checkbox"/> Family/caregiver education <input type="checkbox"/> Voice disorders <input type="checkbox"/> Emergency Plan

Patient/Family response and adherence to teachings: ___ Good ___ Fair ___ Poor ___ Repetitive teaching required

Goals Met: ___ Yes ___ No If No, explain _____

Patient/Family Goals Met: ___ Yes ___ No If No, explain _____

Employee's Signature: _____ Title _____ Date ____/____/____

THERAPY DISCHARGE SUMMARY

PATIENT _____ TO: DR. _____
 CR# _____ HIC# _____ ADDRESS _____
 SOC _____ 1st VISIT _____ CITY _____ ZIP _____
 D/C DATE _____ COMPLETE or PARTIAL — continued services _____
 REASON FOR DISCHARGE: _____
 NUMBER OF VISITS: PT _____ OT _____ SLP _____ MSS _____ AIDE _____
 DIAGNOSES: _____

ADMISSION STATUS

DISCHARGE STATUS

Pain due to _____, level _____ ROM _____ Strength and Endurance _____ Balance _____ Coordination _____ Bed Mobility _____ Transfers _____ Ambulation _____ Fine Motor Coordination _____ Sensory/ Perceptual Awareness _____ Sensory/Perceptual Coordination _____ Receptive Communication _____ Expressive Communication _____ Swallowing _____ Knowledge level of Disease Process _____ HEP _____ Treatments _____ Care Management _____ Safety _____ Other _____ Other _____	Pain due to _____, level _____ ROM _____ Str/End _____ Balance _____ Coordination _____ Bed Mobility _____ Transfers _____ Ambulation _____ Fine Motor Coord _____ S/P Awareness _____ S/P Coord _____ Receptive Com _____ Expressive Com _____ Swallowing _____ Knowledge level of Disease Process _____ HEP _____ Treatments _____ Care Management _____ Safety _____ Other _____ Other _____
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PROBLEMS IDENTIFIED AFTER START OF CARE: _____

SELF CARE ACTIVITY ON ADMISSION: _____

At d/c: Self Care resumed; or Assist to be provided by _____,
 or Transferred to _____

CARE PROVIDED: Observation/Evaluation, Instruction, Personal care as ordered,
 Treatments as ordered, Other _____

UNMET NEEDS: _____

INSTRUCTIONS FOR CONTINUING CARE NEEDS: Equipment management, Physician follow-up,
 Home program, Other _____

ADDITIONAL COMMENTS/ Referrals made: _____

Physician contacted on _____ and discharge is approved.

Therapist Signature _____ Date _____

PHYSICAL THERAPY GOALS REACHED

<p>POC (485) GOALS REACHED:</p> <ul style="list-style-type: none"> <input type="checkbox"/> PATIENT DEMONSTRATED CORRECT BODY MECHANICS <input type="checkbox"/> PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM <input type="checkbox"/> ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN <input type="checkbox"/> DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM <input type="checkbox"/> IMPROVED THE USE OF ASSISTIVE DEVICE: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM <input type="checkbox"/> PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST <input type="checkbox"/> INCREASED STRENGTH OF <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____. <input type="checkbox"/> INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN _____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.
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<p>CARE PLAN SHORT/LONG TERM GOALS REACHED:</p> <p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gait increased tinetti gait score to _____ / 12 <input type="checkbox"/> Improved gait requiring _____ to _____ from _____ to _____ <p>BED MOBILITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. able to turn side (facing up) to lateral (left/right) <input type="checkbox"/> Pt. able to lie back down <input type="checkbox"/> Pt. able to sit up independently _____ <input type="checkbox"/> Pt. able to self reposition <input type="checkbox"/> IMPROVED BED MOBILITY (INDEPENDENT) <p>BALANCE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increased tinetti balance score to _____/16 <input type="checkbox"/> Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance <p>TRANSFER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. able to transfer from _____ to _____ with/without assistance <input type="checkbox"/> INDEPENDENT WITH TRANSFER SKILLS <p>STAIR/UNEVEN SURFACE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. able to climb stair/uneven surface with/without assistance _____ steps # _____ 	<p>MUSCLE STRENGTH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. able to hold weigh _____ lb <input type="checkbox"/> Pt. able to oppose flexion or extension force over _____ <p>PAIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain decreased from _____/10 to _____/10 <input type="checkbox"/> DEMONSTRATED EFFECTIVE PAIN MANAGEMENT <input type="checkbox"/> PATIENT EXPERIENCED A DECREASE IN PAIN <p>ROM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. increased ROM of _____ by _____ degrees flexion/extension <p>SAFETY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pt. able to use _____ independently to _____ feet <input type="checkbox"/> Pt. able to self propel wheel chair _____ feet <input type="checkbox"/> Pt able to finalize and demonstrated to follow up HEP. <p>OTHER:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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ADDITIONAL SPECIFIC THERAPY GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

<p>DISCHARGE INSTRUCTIONS DISCUSSED WITH: <input type="checkbox"/> Patient/Family <input type="checkbox"/> Care Manager <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify) _____</p> <p>CARE WAS COORDINATED: <input type="checkbox"/> Physician <input type="checkbox"/> OT <input type="checkbox"/> SN <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> Aide <input type="checkbox"/> PTA <input type="checkbox"/> Other (specify) _____</p>	<p>DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.</p> <ul style="list-style-type: none"> <input type="checkbox"/> RETURNED TO INDEPENDENT LEVEL OF SELF CARE. <input type="checkbox"/> ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____
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<p>REHAB STATUS: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent</p> <ul style="list-style-type: none"> <input type="checkbox"/> DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED <input type="checkbox"/> ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE 	<ul style="list-style-type: none"> <input type="checkbox"/> ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.
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Goals documented by: _____ Date: _____
Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#
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OCCUPATIONAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- DEMONSTRATED PROPER USE OF PROSTHESIS/BRACE/SPLINT DEMONSTRATED PROPER USE OF DME/HME.
- PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN ADL'S, IADL'S.
- DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- IMPROVED THE USE OF ORTHOTIC, SPLINTING AND/OR EQUIPMENT, ASSISTIVE DEVICE: _____

- MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN MUSCLE USE, MOTOR COORDINATION
- INCREASED STRENGTH OF RUE LUE RLE LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN NEURO RESPONSE
- DISCHARGE PLANNED DISCUSSED WITH PATIENT / FAMILY

CARE PLAN SHORT/LONG TERM GOALS REACHED:

- Patient able to finalize and demonstrate to follow up HEP.
- Pain level decreased from ___/10 to ___/10
- Pt. able to stand in kitchen to prepare meal for ___ min
- Patient able to reach _____ on _____
- Patient able to lift ___ # pounds from ___ to ___
- Patient able to wash _____
- Patient able to reach a Cup from _____ and taked to _____
- Patient able to integrate orthotic/prosthetic _____ to _____
- Patient independent with safety issues in _____
- Improved bathing skills, use to _____
- Patient retraining of cognitive, feeding, and perceptual skills
- Patient able to improve body image with _____
- Independent with muscle re-education

- Increased strength R L Hands
- Increased coordination R L Hands
- Increased sensation R L Hands
- Increase Neuro response by _____
- Use of SPLINTING AND/OR EQUIPMENT independent
- Demonstrate Hands motion to WNL within

OTHER:

OTHER:

ADDITIONAL SPECIFIC OT GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: Patient/Family
 Care Manager Physician Other (specify) _____

CARE WAS COORDINATED: Physician PT SN ST
 MSW Aide OTA Other (specify) _____

- DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: Poor Fair Good Excellent

- DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE

- ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Therapist Name/Signature/title Date _____

PATIENT NAME - Last, First, Middle Initial

ID#

SALUD HOME CARE

Discharge letter Notification to Patient/Family
(Spanish Translation in the Back)

Dear: _____

Please be advised that as of ____/____/____ you have been discharged from our Home Health Care Agency. We have mailed you final discharge summary to your physician.

We hope that your care was of a more than satisfactory nature. Please complete the "Patient Survey" that is included in your patient package and return mail it to us.

We wish you will continue with good health. Please remember to take your medications as prescribed by your physician and to follow-up visit your visit your physician per his/her request.

Please call us should you need further or additional assistance.

Sincerely,

Director of Nursing or Qualified Designee

Date

Carta de Información de Alta al Paciente/Familia

Por favor, usted está siendo avisado(a) de que en la siguiente fecha ____/____/____ será dado de alta de nuestra Agencia de Cuidados de Salud en el Hogar. Nosotros le hemos enviado por correo a su médico el sumario de su alta final.

Esperamos que su cuidado haya sido más que satisfactorio. Por favor complete la “Encuesta del Paciente” incluido en los papeles dejados en su casa y retornarlo por correo a nosotros.

Nosotros deseamos que usted continúe con buena salud. Por favor, recuerde tomar sus medicamentos como han sido prescritos por su doctor y seguir todas las indicaciones de el/ella.

Por favor, llámenos si usted necesitara asistencia adicional.

Firmas