INTERDISCIPLINARY DISCHARGE SUMMARY

INSTRUCTIONS: Complete this form when a resident is discharged. All items must be addressed. Record additional comments/notes on the reverse.

RECAPITULATION OF RESIDENT'S STAY

Admission date _____/_____/_____ Discharge date _____/_____/_____

Reason for admission: _____

Treatment provided: _____

_____

Progress (include any complications experienced): _____

_____

Reason for discharge/discharge diagnosis(es): _____

FINAL SUMMARY OF THE RESIDENT'S STATUS

SOCIAL SERVICES

Sensory impairments _____

_____

Mental and psychosocial status: ❑ Able to make needs known ❑ Unable to make needs known

Attitude about discharge (describe) _____

Cognitive status _____

_____

Discharge potential _____

Local Contact Agency notified? ❑ Yes, date_____/_____/_____ ❑ Not utlilized

SOCIAL SERVICES DIRECTOR _____ Date_____/_____/_____

Signature and title

❑ Additional Social Services notes on reverse.

Personal Belongings sent: ❑ with resident ❑ with family ❑ Other _____

NURSING SERVICES

Vital signs at time of discharge: Temp._____ Pulse_____ Resp._____ BP_____/_____

Clinical lab values or diagnostic tests: _____

Physical functioning status: ❑ Ambulatory ❑ Nonambulatory ❑ Needs assist with ADLs ❑ No ADL assist needed

❑ Assistive device(s) needed (specify) _____

Other comments: _____

_____

Special treatments or procedures planned for discharge: ❑ None ❑ P.T. ❑ S.T. ❑ O.T. ❑ Ostomy ❑ G Tube

❑ NG Tube ❑ Other _____

_____

Dental condition: ❑ Own teeth ❑ Upper dentures ❑ Lower dentures ❑ Partial dentures ❑ No teeth or dentures

❑ Refuses to use dentures ❑ Teeth/mouth problems (specify) _____

Drug therapy required _____

_____

NURSE SIGNATURE _____ Date_____/_____/_____

Signature and title

❑ Additional Nursing Service notes on reverse. Disposition of Meds_____

DIETARY SERVICES

Weight_____ Height_____ Weight trend _____

❑ Chewing problems ❑ Swallowing problems ❑ Needs assist (specify) _____

Eating habits/preferences _____

_____

Diet order:_____ Texture:_____ Allergies:_____

DIETARY DIRECTOR _____ Date_____/_____/_____

Signature and title

❑ Additional Dietary Service notes on reverse.

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

INTERDISCIPLINARY DISCHARGE SUMMARY

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

ACTIVITIES

Activity pursuit: _____

_____

Activities potential: _____

_____

ACTIVITIES DIRECTOR _____ Date _____/_____/_____
Signature and title

❑ Additional Activities notes below.

REHAB. SERVICES

Rehabilitation potential: _____

_____

_____

Assistive devices: _____

THERAPIST _____ Date _____/_____/_____
Signature and title

❑ Additional Rehab. notes below.

ADDITIONAL COMMENTS/CONCERNS – All entries must be signed and dated.