University of Medical Center

Discharge Instructions/Orders

PATIENT I -NTIFICATION

This form is to be completed by the discharging resident/practitioner
All appointments must be made by Patient or Patient Representative

Appointment	MD/Team/Clinic	Date/Day	Time	Telephone
Other Referral				
Other Referral	Home Health Agency			

Discharge Date ______________ **Time** ______________
D/C Location: ☐ Home ☐ Nursing Home ☐ Sub-acute ☐ Other ______________

D/C Mode: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Carried
Accompanied by: ☐ Family ☐ Friend ☐ Self ☐ Other
Transportation: ☐ Ambulance ☐ Car ☐ Taxi ☐ Bus ☐ Other

Medications	Dosage Form (Tabs/Pills, etc.)	Dosage Amount (mg, ml, etc.)	How often	Reason	Special Considerations
1.					
2.					
3.					
4.					
5.					
6.					
7.					

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PATIENT EN[illegible]

Treatments/ Dressings	Describe ______
Diet	☐ Resume usual diet ☐ *Diabetic ☐ *Low Salt ☐ *Low fat ☐ *Cardiac/Heart Healthy ☐ Other ______ ☐ Restrictions ______ *Instructions given by: ☐ Dietitian/Dietetic Technician ☐ RN If patient has a cardiac diagnosis monitor weight daily. If there is a 2-3 pound weight gain over 1-3 days, contact your physician.
Activity	☐ Resume usual activity ☐ No heavy lifting ☐ No driving until MD visit ☐ Bedrest ☐ Special equipment ______ ☐ Mobility Limitations ______ ☐ Limit sexual activity until ______ ☐ Other ______
Hygiene	☐ As before ☐ Tub bath ☐ May shower ☐ Sponge bath only ☐ Other ______
Education	☐ **Education information and/or handout given to patient/family. (See patient/family education summary in Medical Record and/or specialized pre-printed discharge form for additional instructions. (i.e, Ortho Discharge Instruction Form)).** **Smoking and/or exposure to second-hand smoke is harmful to you and your family's health. If you would like information on Smoking Cessation, ask your nurse.**
WHEN TO CALL THE DOCTOR	***Call your Health Care Provider if you:*** If pain plan is ineffective, call: ______
Outcome	**Patient and or significant other verbalizes understanding of:** ☐ discharge instructions and follow-up plans ☐ medication regimen, action, side effects and food interaction ☐ how to manage pain and who to call if ineffective ☐ prescriptions given ☐ labeled medications given ☐ other ______
Return to School/Work	May return to school / work on ______
MD/Resident/ DO/NP/PA	**Signature of Discharging Resident/Practitioner** **Printed Name** **MD ID No:** **Date** **Discharging Attending Printed Name** **MD ID No:** **Date** **(To be completed by Discharging Resident/Practitioner)**
RN	Signature Printed Name Date My signature means that I have reviewed this form with the patient, recipient, patient representative.
Patient/Family	Signature Printed Name Date My signature means that I understand all instructions on this form.

Form Number DS1 (11/04)

White - Medical Records Yellow - Physician/Unit Copy Pink - Patient Copy