

INITIAL AND FINAL DISCHARGE PLAN

Patient Name _____ Patient No. _____

Physician _____ Admission Date _____

Diagnosis _____

Responsible person _____ Telephone _____

Discharge Plans at time of Admission to Swing Bed Program _____

Rehab potential: Excellent Good Fair Poor Negative

Goals for Discharge: Self Care Family Care HHA Services Nursing Home Placement
 Community Resources Re-hab unit Home with Hired Help Lifeline unit

Location of patient prior to hospitalization: _____

Special Needs anticipated at time of discharge:

Diet _____

Therapy _____

Wound Care _____

Medications _____

Educational Needs _____

Social and/or Enviromental Needs: _____

Have referral agencies been contacted: _____

 If yes, list agency, date of contact and expected outcome.

At time of discharge Date _____

Independence in ADLS _____

Nursing Service Assessment _____

Social Service Designee _____

Dietician Assessment _____

Therapist Assessment (if any) _____

If final disposition of patient differed from initial plan, please state outcome, reason of change, and patient's acceptance of change.

See also nursing discharge summary for instructions.

Date _____ Discharge Coordinator (SB) _____