COUNTY HOSPITAL

DISCHARGE INSTRUCTIONS

REFERRALS: ☐ No referrals needed

	Name of Referred Service	Contact Number
☐ Home Health		
☐ Equipment		
☐ _____		

SMOKING CESSATION

- If you smoke, it is **VERY IMPORTANT** to stop.
- Avoid secondhand smoke.
- Call your local health department to ask for services to help you stop.

DIET: ☐ No restrictions ☐ Low fat / cholesterol ☐ _____ ☐ Instructions given

☐ **Congestive Heart Failure: Low sodium, low fat diet. Eat foods rich in potassium such as bananas and raisins. Drink orange juice and other citrus juices.**

☐ **FOOD / DRUG INTERACTION EDUCATION PROVIDED**

ACTIVITY: ☐ No restrictions / As tolerated ☐ Return to work / school_____

☐ No driving for _____ days / weeks ☐ _____

☐ Follow up appointment with Dr. _____ on _____ at_____. Phone number:_____

☐ Please make a follow up appointment with Dr. _____ in _____ weeks Phone number:_____

☐ **CONGESTIVE HEART FAILURE: Signs & symptoms to watch for**

- Shortness of breath with light activity or shortness of breath at night when lying down flat.
- Puffiness or swelling of your feet, ankles, hands or eyes. Feeling bloated in belly.
- A constant dry cough or a productive cough with pinkish sputum.
- Weigh yourself each morning after you empty your bladder. Call your physician if your weight increases more than **3 pounds in 2 days.**
- If any of the above symptoms worsen, notify your physician immediately.

☐ **WOUND CARE**

☐ **SPECIAL INSTRUCTIONS**

☐ **Medication Safety Information**

- Take all medications exactly as prescribed and do not skip doses.
- Be aware of foods that could interact with your meds.
- Do not share your medications with other people.
- Check with your pharmacist before taking over-the-counter medications or herbal supplements that could interact with other medications.
- Do not use alcohol or operate machinery if on sedating medications such as pain medications.

☐ **Other**

Referral	Activity / Work Release
Pt. Name_____	Pt. Name _____
☐ See your private physician ☐ in _____ days ☐ if symptoms persist or worsen	No PE / Sports until_____
☐ See Doctor_____in_____days	Return to work / school _____
☐ Telephone No._____	Return to work with restrictions _____

Note: If you are unable to see your physician in the suggested period of time or feel your condition persists or worsens, please return to the Emergency Department.

My signature indicates that I have received the instructions, verbalized that I understand them, and am able to manage my continuing care after discharge. If I have been referred to a physician for continued medical care then I will do so. I am leaving with all of my personal belongings and valuables.

Signed / Relationship to Patient	Date
Designated Driver	Nurse / Physician

Rev. 10/05