POST-DISCHARGE PLAN OF CARE

The following information is to help you maintain your health and independence after discharge from _______________________________. If you have questions, please call us at ____________________.

You are being discharged: ❍ home ❍ to another facility.

Discharge Destination: ______________________________________ Phone: ______________
(Facility Name)

Address (include City/State/Zip): ____

IMPORTANT NAMES AND PHONE NUMBERS

Physician: ______________________________________ Phone: ______________
Name and address

Pharmacy: ______________________________________ Phone: ______________
Name and address

MEDICATIONS

Name of Medication	Dose	Amt.	How Often	Reason and Special Instructions	Amount Sent With Resident	Prescription Sent With Resident	Prescription Called To Pharmacy
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes
						❍ No ❍ Yes	❍ No ❍ Yes

Person completing this section: ______________________ ____________ ____________
Signature and title *Date* *Time*

SCHEDULED APPOINTMENTS

Appointment With	Date	Time	Reason	Phone Number

DIET

Recommended Diet: ____

Limit: ❑ Sugar ❑ Salt ❑ Calories: __________ ❑ Fluids: __________ ❑ Other: ______________

Special Instructions/Recommendations: ____

____

Person completing this section: ______________________ ____________ ____________
Signature and title *Date* *Time*

ACTIVITY

❍ Limit activities to: ____

Duration: ❍ 1 week ❍ 1 month ❍ Other: ____________________ ❍ No limitation with activity

Person completing this section: ______________________ ____________ ____________
Signature and title *Date* *Time*

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

CFS 2-2/2P Rev. 2/18

BRIGGS Healthcare

Continued on Reverse

POST-DISCHARGE PLAN OF CARE

WOUND/SKIN CARE

❍ No special care or treatment ❍ Special care/treatment - see directly below

Area	How Often	Reason	Instructions

❑ Supplies sent with at time of discharge ❑ Instructions/details provided on separate document

Person completing this section:_____ _____ _____
Signature and title *Date* *Time*

EVERYDAY FUNCTIONS

Function	Self	Needs Help	Can't Do	Comment	Function	Self	Needs Help	Can't Do	Comment
Moving bed to chair	❍	❍	❍		Bathing	❍	❍	❍	
Moving about in bed	❍	❍	❍		Brushing teeth	❍	❍	❍	
Walking	❍	❍	❍		Hair care	❍	❍	❍	
Climbing stairs	❍	❍	❍		Driving car/Transportation	❍	❍	❍	
Toileting	❍	❍	❍		Housekeeping	❍	❍	❍	
Dress/Undress	❍	❍	❍		Using cane, walker or WC	❍	❍	❍	
Eating/Meal preparation	❍	❍	❍		Other:	❍	❍	❍	

Person completing this section:_____ _____ _____
Signature and title *Date* *Time*

THERAPY(IES) NEEDS

❍ No therapy ordered ❍ Therapy ordered - see directly below

Therapy Type	How Often	Reason	Where Provided	Instructions

❑ Instructions/details provided on separate document

Person completing this section:_____ _____ _____
Signature and title *Date* *Time*

COMMUNITY RESOURCES/SERVICES

Contact	Phone	Mailing Address	Email Address
State Long-Term Care Ombudsman			
Home Health Agency or Visiting Nurse			
Meals on Wheels			
Hospice			
Medical Equipment Supplier			
Local Medicaid Office			
Other:			

Person completing this section:_____ _____ _____
Signature and title *Date* *Time*

These discharge instructions have been reviewed with me in a language I understand. All current questions have been answered to my satisfaction. I understand that I may call this facility if I have more questions. I have received the medications or written prescriptions as indicated. I am leaving this facility with a copy of this document.

Signature: **X**_____ _____ _____
Resident *Date* *Time*

Signature:_____ _____ _____
Resident Representative/Caregiver *Date* *Time*

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