DISCHARGE PLAN/DISCHARGE PLAN REVIEW

INSTRUCTIONS: Record admission date, anticipated length of stay, admitting diagnoses and goals/plans for discharge in the fields provided. Add new pertinent diagnoses as appropriate. In the Resident Status section, check all applicable items. Use the space provided for additional pertinent information. Complete the remainder of the form. Record comments as the discharge plan and resident status is reviewed for potential discharge on the back of the form.

DATE OF ADMISSION_____ **ANTICIPATED LENGTH OF STAY**_____

Admitting/Current Diagnoses	Onset Date (if known)	Admitting/Current Diagnoses	Onset Date (if known)

RESIDENT/RESIDENT REPRESENTATIVE GOAL/EXPECTATION FOR DISCHARGE _____

_____

RESIDENT STATUS UPON ADMISSION

Mental Status	Behavior/Emotions	Ambulation/Mobility	Impairments
❍ Alert	❑ Cooperative	❍ Independent	❑ Hearing
❍ Oriented x _____	❑ Disruptive	❍ Assist	❑ Speech
❍ Confused	❑ Combative	❑ Cane	❑ Sensation
❍ Forgetful	❑ Withdrawn	❑ Walker	❑ Vision
❍	❑ Social	❑ Wheelchair	❑
Diet	❑ Suicidal	❑	❑
❍ Regular	❑ Substance Use Disorder (SUD)	**Transfer**	**Dressing/Clothing**
❍ Ground	❑	❑ Bed to wheelchair/chair	❍ Independent ❍ Assist ❍ Total
❍ Pureed	**Care Status**	❑ Wheelchair/chair to toilet	❑ Upper extremities
❍ Tube fed	❑ Bed	❑ Wheelchair/chair to tub	❑ Trunk
❍	❑ Chair	❍ 1 person assist	❑ Lower extremities
Eating	❑ If up daily, how long?	❍ 2 person assist	❑ Prosthesis-type:
❍ Independent	❑	❍ Independent	❑
❍ Assisted	**Incontinence/B&B Status**	**Hygiene, Assist with**	❑
❍ Fed	❑ Bladder	❑ Bathing	**Potential for Discharge**
❑ Adaptive Equipment	❑ Bowel	❑ Oral	❍ Good
❑	❑ Catheter	❑ Hair	❍ Poor/Guarded
❑	❑ Ostomy	❑ Shaving	❍ No Potential
❑	❑	❑	❍ Terminal Status

PHYSICIAN'S INPUT REGARDING DISCHARGE

_____

_____

_____

RESIDENT/RESIDENT REPRESENTATIVE(S) REACTION TO DISCHARGE PLAN

_____

_____

_____

COMMUNITY AND REFERRAL RESOURCES RE: RESIDENT'S DISCHARGE

Referral to local contact agency? ❍ Yes, date_____ ❍ No: explain why_____

_____

INDIVIDUAL COMPLETING DISCHARGE PLAN_____ _____
Signature/Title Date

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

DISCHARGE PLAN REVIEW

INSTRUCTIONS: §483.15(c) requires the location the resident is discharging to meets the resident's needs, provides them with necessary supports and resources, and is a location that is selected based on resident preferences. If the resident is discharging with a caregiver, this requirement expects the caregiver has the availability and capacity to meet such needs. Discharge planning also requires consideration of the resident's ability or inability to provide self care. The interdisciplinary team should consider each aspect of the regulatory standards while reviewing and planning for a safe and orderly resident discharge.

COMMENTS RELEVANT TO DISCHARGE PLAN

DATE REVIEWED:__________________ **NEXT REVIEW:**__________________

Referral to local contact agency? ❍ Yes, date__________________ ❍ No: explain why____________________

REVIEWING INDIVIDUAL______________________________ ______________
Signature/Title Date

COMMENTS RELEVANT TO DISCHARGE PLAN

DATE REVIEWED:__________________ **NEXT REVIEW:**__________________

Referral to local contact agency? ❍ Yes, date__________________ ❍ No: explain why____________________

REVIEWING INDIVIDUAL______________________________ ______________
Signature/Title Date

COMMENTS RELEVANT TO DISCHARGE PLAN

DATE REVIEWED:__________________ **NEXT REVIEW:**__________________

Referral to local contact agency? ❍ Yes, date__________________ ❍ No: explain why____________________

REVIEWING INDIVIDUAL______________________________ ______________
Signature/Title Date

COMMENTS RELEVANT TO DISCHARGE PLAN

DATE REVIEWED:__________________ **NEXT REVIEW:**__________________

Referral to local contact agency? ❍ Yes, date__________________ ❍ No: explain why____________________

REVIEWING INDIVIDUAL______________________________ ______________
Signature/Title Date

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