INTERDISCIPLINARY DISCHARGE SUMMARY

INSTRUCTIONS: Complete form when a resident is discharged from or dies in the facility. All items must be addressed. Record additional comments/notes on page 2. In addition, complete the medication reconciliation/information on the last two pages.

RECAPITULATION OF RESIDENT'S STAY

Admission date_____ Discharge date_____ Discharged to:_____ ❑ Expired
Reason for admission/diagnoses:_____
Services/treatment provided:

Progress (include any complications experienced):

Reason for discharge/diagnoses at discharge/death:_____
Primary Care Physician at time of discharge/death:_____

FINAL SUMMARY OF THE RESIDENT'S STATUS

SOCIAL SERVICES

Sensory impairments: ❍ No ❍ Yes:_____
Hearing Aid(s): ❍ No ❍ Yes ❍ Rt ❍ Lt ❍ Bilateral Glasses: ❑ No ❑ Yes Advance Directives: ❍ No ❍ Yes ❑ Attached
Mental/psychosocial: ❍ Able to make needs known/own decisions ❍ Unable to make needs known/unable to make decisions
BIMS: _____(Admit)|_____(Discharge) Most recent mood score:_____ Date:_____ ❍ Interview ❍ Staff
Attitude about discharge:_____
Local Contact Agency notified? ❍ Not needed ❍ Yes, date _____
Referrals made: ❑ Home Health ❑ Meals on Wheels ❑ Senior Citizen/Elder Agency:_____
❑ Hospice ❑ Laboratory ❑ Outpatient therapy ❑ Other:_____
Personal belongings sent: ❑ With resident ❑ With family ❑ Other:_____
Preferred language:_____ Needs interpreter: ❍ No ❍ Yes

SOCIAL SERVICES SIGNATURE/TITLE_____ Date_____
❑ Additional Social Services notes on page 2

NURSING SERVICES

Vital signs at discharge: Temp_____ Pulse_____ Resp_____ BP_____ _____ AP_____ O_2 Sat_____
Clinical lab values or diagnostic tests:_____
Physical functioning: ❑ Ambulatory ❑ Non-ambulatory ❑ Needs assist with ADLs ❑ No ADL assist needed ❑ Fall risk
❑ Assistive device(s) needed: ❍ No ❍ Yes:_____
❑ Prosthesis ❍ No ❍ Yes:_____
Behavior issues: ❍ No ❍ Yes:_____ Pain: ❍ No ❍ Yes:_____
Special treatments or procedures planned after discharge: ❑ None ❑ PT ❑ ST ❑ OT ❑ Ostomy ❑ PEG Tube ❑ NG Tube
❑ IV meds/fluids ❑ Oxygen ❑ Wound care ❑ Indwelling catheter ❑ BiPAP/CPAP ❑ Other:_____
Dental condition: ❑ Own teeth ❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Refuses to use dentures
❑ No teeth or dentures ❑ Teeth/mouth problems (specify)_____
Skin condition: ❑ Intact ❑ Surgical wound ❑ Pressure injury ❑ Other:_____
Describe status if other than intact:_____
Wander risk: ❍ No ❍ Yes:_____
Allergies: ❍ No ❍ Yes Food:_____ Drug:_____ Other:_____
Other comments:_____

NURSE SIGNATURE/TITLE_____ Date_____
❑ Additional Nursing Service notes on page 2

DIETARY STATUS

Weight_____(Admit)|_____(Discharge) Height_____ Weight trend during stay:_____
❑ Chewing problems ❑ Swallowing problems ❑ Needs assist (specify) _____
Eating habits/preferences:

Diet order:_____(Admit)|_____(Discharge) Texture:_____(Admit)|_____(Discharge) Liquid consistency:_____(Admit)|_____(Discharge)

DIETARY SIGNATURE/TITLE_____ Date_____
❑ Additional Dietary Service notes on page 2

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

INTERDISCIPLINARY DISCHARGE SUMMARY

MED RECORDS

Current reconciled medication list provided to subsequent provider: ❍ No ❍ Yes

How provided: ❍ Electronic Health Record ❍ Verbal (phone, in-person, video conferencing)
❍ Health Information Exchanges ❍ Paper-based (FAX, copies, printouts) ❍ Other (email, text, CD)

Current reconciled medication list provided to resident, family, caregiver: ❍ No ❍ Yes

How provided: ❍ Electronic Health Record ❍ Verbal (phone, in-person, video conferencing)
❍ Health Information Exchanges ❍ Paper-based (FAX, copies, printouts) ❍ Other (email, text, CD)

❑ Additional Medication Reconciliation notes below

ACTIVITIES

Activity interest/involvement during stay:

ACTIVITIES SIGNATURE/TITLE_____ Date_____

❑ Additional Activities notes below

REHAB SERVICES

Rehabilitation summary (include goals met/unmet):

Follow-up rehab needed: ❍ No ❍ Yes, specify_____

THERAPIST SIGNATURE/TITLE_____ Date_____

THERAPIST SIGNATURE/TITLE_____ Date_____

THERAPIST SIGNATURE/TITLE_____ Date_____

❑ No rehabilitation services provided

❑ Additional Rehab notes below

ADDITIONAL COMMENTS/CONCERNS – All entries must be signed and dated

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

INTERDISCIPLINARY DISCHARGE SUMMARY

MEDICATION AT DISCHARGE (Prescribed and OTC)	DOSE	FREQUENCY	ROUTE	REASON/DIAGNOSIS	MEDICATION DISPOSITION ON DISCHARGE
					❍ Sent with resident ❍ Rx called in to pharmacy; will pick up ❍ Returned to pharmacy ❍ Destroyed in facility ❍ Other: ________
					❍ Sent with resident ❍ Rx called in to pharmacy; will pick up ❍ Returned to pharmacy ❍ Destroyed in facility ❍ Other: ________
					❍ Sent with resident ❍ Rx called in to pharmacy; will pick up ❍ Returned to pharmacy ❍ Destroyed in facility ❍ Other: ________
					❍ Sent with resident ❍ Rx called in to pharmacy; will pick up ❍ Returned to pharmacy ❍ Destroyed in facility ❍ Other: ________
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NAME–Last First Middle	Attending Physician	Record No.	Room/Bed

INTERDISCIPLINARY DISCHARGE SUMMARY

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