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/therapy/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

§483.15(c) requires the location the resident has discharged to meets the resident's needs, provides them with necessary supports and resources, and is a location that was selected based on resident preferences. If the resident was discharged 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. As such, it is recommended that each section below is completed thoroughly and all actions taken to ensure a safe and orderly resident discharge is documented accordingly.

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:_____ ❍ Resident 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
Other post-discharge arrangements related to the resident's follow-up care or services:_____
_____

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_____
Relevant lab, radiology, and consultation results:_____
Physical functioning: ❑ Ambulatory ❑ Non-ambulatory ❑ Needs assist with ADLs ❑ No ADL assist needed ❑ Fall risk
❑ Assistive device(s) needed: ❍ No ❍ Yes:_____
❑ Prosthesis: ❍ No ❍ Yes:_____
❑ History of falls: ❍ 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

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

INTERDISCIPLINARY DISCHARGE SUMMARY

ACTIVITIES

Activity interest/involvement during stay:_____

_____

ACTIVITIES SIGNATURE/TITLE_____ Date_____

❑ Additional Activities notes below

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 below

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

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	ROUTE	FREQUENCY	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: ____________
					❍ 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: ____________

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

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