# Discharge/Transfer of Patient Form

Use this form when permanently discharging or transferring a patient from your facility.

## Admission Date:          Discharge Date: 

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharged to:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

| Phone: (   )  - |

<table>
<thead>
<tr>
<th>Principal diagnosis upon admission:</th>
<th>Surgery this admission:</th>
<th>Date:</th>
<th>Other active medical problems:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Allergies (list and describe reactions):</th>
<th>Active infection(s) in existence this admission and site:</th>
</tr>
</thead>
</table>

## Physician treatments/orders - Please specify number and frequency:

<table>
<thead>
<tr>
<th>Diet:</th>
<th></th>
</tr>
</thead>
</table>

**Condition at discharge:**  
- [ ] Improved  
- [ ] Unchanged from admission  
- [ ] Skilled Home Nursing Care  
- [ ] Physical Therapy  
- [ ] Respiratory Therapy  
- [ ] Occupational Therapy  
- [ ] Speech Therapy

**Additional physician comments:**

<table>
<thead>
<tr>
<th>List ALL medication(s) to be taken after discharge: (Include dose and frequency. Indicate if medication is new.)</th>
</tr>
</thead>
</table>

**NOTE:** Nursing homes must have prescriptions for Schedule II medications.

<table>
<thead>
<tr>
<th>New prescriptions:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Instructions until next doctor visit</th>
<th>Allowed</th>
<th>Allowed with supervision</th>
<th>Not allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive car or ride a bike</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower/tub bath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifting (weight limit lbs.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with non-clinical people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight bearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stair climbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in gym class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact/non-contact sports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return to work/school/class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resume sexual activity</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Discharging facility contact person:

| Phone: (   )  - |

**The following information MUST be attached for discharge to a nursing or other facility:**  
- [ ] Patient demographic/registration sheet  
- [ ] Medications and IV sheets  
- [ ] Most recent lab results

<table>
<thead>
<tr>
<th>Discharging facility contact person:</th>
<th></th>
</tr>
</thead>
</table>

| Phone: (   )  - |

## Attending physician’s signature:

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
</table>

**Discharge summary dictated by:** (please print)

<table>
<thead>
<tr>
<th>Physician who will follow this patient after discharge:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Phone: (   )  -</td>
</tr>
</tbody>
</table>

**Physician notified:**  
- [ ] Yes  
- [ ] No

<table>
<thead>
<tr>
<th>ORIGINAL: Agency/patient</th>
<th>COPY: Physician(s)/agency</th>
<th>COPY: Chart</th>
</tr>
</thead>
</table>
Patient Name: 

Does the patient have documents for end-of-life care?
- MOLST
- DNR
- DPA

Immunization(s) this admission:
- Flu
- Pneumonia

Discharged to:
- Home
- Home care/services
- Rehab
- Nursing home
- Other:

Visit(s) scheduled for:
- Written information on medications
- Pain management instructions
- Congestive heart failure brochure
- Food/drug interaction information
- Therapeutic diet instructions
- Comfort-One Band
- Drug/drug interaction information
- Smoking cessation brochure

Information given to patient on discharge:

Isolations/Precautions

<table>
<thead>
<tr>
<th>Positive Culture</th>
<th>Site</th>
<th>Date Resolved</th>
<th>Prior History</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.Diff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESBL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Referral to:

Agency: 
Phone: ( ) -

Medications:

Nurse includes the actual time(s) prescription(s) are to be taken and the next time the drug is due.

<table>
<thead>
<tr>
<th>Pre-admission</th>
<th>New</th>
<th>Dose</th>
<th>Frequency</th>
<th>Time last given</th>
<th>Time next dose</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continue after discharge

Nurse's signature: 
Title: 
Date: 
Phone: ( ) -

Comments:
Patient Name:                   Date: 

Activities of daily living on discharge day  
CODES:  
0 = Independent  
1 = Supervision  
2 = Limited Assistance  
3 = Extensive Assistance  
4 = Total dependence  
5 = Activity did not occur  

Mobility:  
Upper extremities  
Lower extremities  
Field: Normal  
Impaired  

Amputee  
Prosthesis use  
Equipment needed on discharge  

Diagnosis stage and location of all pressure injuries.  
Stg 1 - non-blanchable erythema of intact skin  
Stg 2 - partial-thickness skin loss with exposed dermis  
Stg 3 - full-thickness skin loss  
Stg 4 - full-thickness skin and tissue loss  
Other wounds present (include unstageable and DTIs)?  
No  
Yes – Describe:  

Bowel and bladder assessment  
Bladder  
Continent  
Occasionally incontinent  
Frequently incontinent  
Incontinent  
Bowel  
Date of last bowel movement:  
Ostomy (type/size):  
Foley type:  
Foley balloon size:  
Date foley changed:  

Dialysis (type):  

Impairments - Hearing/Visual  
Auditory (with hearing appliance, if used)  
Hears adequately  
Minimum difficulty  
Intermittently impaired  
Highly impaired  

Has hearing device  
Type:  

Vision (with glasses, if used)  
Sees adequately  
Impaired - sees large print but not regular print  
Moderately impaired - limited vision, cannot see headlines  
Severely impaired - no vision or only sees light, color, shapes  

Has visual device  
Type:  

Comments: (if necessary to describe any deviation not addressed in nursing discharge summary):  

Vital signs  
Height:  
Pulse range:  
Temp:  
On oxygen @  
LPM  
Pain score:  

No pain  
Mild  
Moderate  
Severe  
Worst pain imaginable  

Describe pain:  

Cognitive skills for daily decision making  
How well does the patient make decisions about organizing the day?  
(Choose one response)  
Independent  
Modified independence - some difficulty in new situation  
Moderately impaired - decisions poor, cues/supervision needed  
Severely impaired - never or rarely decides  

Level of consciousness?  
(Choose one response)  
Alert  
Drowsy, but aroused with minor stimulation  
Requires repeated stimulation to respond  
Responds only with reflex motor or autonomic system  
Unresponsive  

Brief mental health examination  
Patient is oriented to:  
Person  
Yes  
No  
Place  
Yes  
No  
Year  
Yes  
No  
Thought or speech organization is coherent  
Yes  
No  
Maintains attention, not easily distracted  
Yes  
No  
Short term memory OK – recalls 3 items after 5 minutes (i.e., book, tree, house)  
Yes  
No  

Communication  
Primary Language:  
Able to:  
Understand  
Speak  
Read  
Write  

Secondary Language:  
Able to:  
Understand  
Speak  
Read  
Write  

Aphasia:  
Expressive  
Receptive  
Sign language:  
Yes  
No  

Nurse's signature:  
Title:  
Date:  
Phone: (  ) -  

ORIGINAL: Agency/patient  
COPY: Physician(s)/agency  
COPY: Chart
### Discharge/Transfer of Patient Form

**Discipline Specific Summary Notes**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Discipline:</th>
<th>Nursing discharge summary</th>
<th>IV present</th>
<th>Yes – Complete next line:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date IV started:</th>
<th>Time:</th>
<th>IV solution</th>
<th>Meds in IV</th>
<th>Rate:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Contact#/Unit</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Additional information attached:**

<table>
<thead>
<tr>
<th>Discipline:</th>
<th>Additional information attached:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Contact#/Unit</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Additional information attached:**

<table>
<thead>
<tr>
<th>Discipline:</th>
<th>Additional information attached:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Signature:**

**Contact#/Unit:**

**Date:**

---

This information was reviewed and new prescriptions ☐ were ☐ were not provided. I understand these instructions and accept responsibility to carry them out and bring this form to my next doctor/clinic appointment.

**Patient signature:**

**Or if discharged to parent/guardian - name(s)/signatures**

**Interpreter(s) name:**

<table>
<thead>
<tr>
<th>ORIGINAL: Agency/patient</th>
<th>COPY: Physician(s)/agency</th>
<th>COPY: Chart</th>
</tr>
</thead>
</table>