PATIENT DISCHARGE. NOTIFICATION/INSTRUCTIONS
ALTA DEL PACIENTE. NOTIFICACION/INTRUCCIONES

Discharge Date/*Fecha de Alta del Paciente*

Patient Name/*Nombre de el(la) Paciente*

Patient Record Number/*Número de Record del Paciente*

Dear Patient/*Estimado Paciente:*

It has been our pleasure to assist you during your recovery period from your recent illness, in accordance with your private physician's plan of treatment and in compliance with Medicare/Medicaid guidelines, you are being discharged from all home health services.
Ha sido un placer asistirlo durante su periodo de recuperación de su reciente enfermedad. De acuerdo con el plan de tratamiento de su médico y en cumplimiento de las regulaciones de Medicare/Medicaid, Ud. está siendo dado de alta de sus servicios de cuidado a la casa.

l.-Continue to follow any Diet instructions you received/*Continúe las Instrucciones de Dieta Recibidas.*
Current Diet/*Dieta Corriente*

2.-Take Only Medications Prescribed by Your Doctor, Discard all Out-Dated Medications/*Tome Solamente Medicamentos Recetados por su Doctor, Deseche Todos los Medicamentos Expirados.*
Current Medications Include*lMedicamentosActuales lncluyen:* ☐ **See current/updated medication schedule**/*Vea el listado de medicamentos actualizado*
Comment*/Comentarios:*

3.-Continue with the Following Treatments/*Continue con los Siguientes Tratamientos:*
Current Treatments Include/*Tratamientos Actuales Incluyen*

4.-Continue with the Following Activities/*Continue con las Siguientes Actividades:*
Current Activities Include/*Actividades Actuales Incluyen*

Special Precautions*/Precauciones Especiales*

Psychosocial Need Follow/*Necesidades Psycosociales a Seguir*

Community Resource to Contact-Referrals Made/*Recursos de la Comunidad para Contactar o Referir*

Keep Doctor's Name and Phone Number, and Your Address Clearly Printed Next to Your Phone or On Your Refrigerator. Keep Name and Phone Number of Friend or Relative to Be Contacted in Case of Emergency, Next to Your Phone or On Your Refrigerator.
Mantenga Nombre y Teléfono de Su Médico, así como su dirección, claramente escritos Cerca de Su Teléfono o Refrigerador. Mantenga Nombre y Teléfono de un Amigo o Familiar que Pueda Ser Contactado en Caso de Emergencia

Physician Name/*Nombre del Médico*

Phone Number/*Número de Teléfono*

Next Physician Appointment/*Próxima Cita*

Instructions given to/*Instrucciones dadas a*

Relationship to Patient/*Relación con el Paciente*

Patient signature / *Firma del Paciente* Date/*Fecha*

Witness (Agency's Representative)/*Testigo(Representante de la Agencia.)* Date/*Fecha*

FOR EMERGENCY CALL 911 - *EN CASO DE EMERGENCIA LLAME AL 911*

ABSOLUTE
HOME CARE INC

PATIENT DISCHARGE INSTRUCTIONS

PATIENT NAME _____ D/C DATE _____

DIET _____

MEDICATIONS _____

TREATMENTS _____

SPECIAL PRECAUTIONS _____

ACTIVITY _____

WHEN TO CALL THE PHYSICIAN _____

SAFETY/DISASTER PLAN _____ **FOR EMERGENCY CALL 911**

COMMUNITY RESOURCES AVAILABLE TO HELP YOU _____

IMPORTANT PHONE NUMBERS

PHYSICIAN _____ PH. _____ NEXT APPT _____
PHARMACY _____ EQUIP _____ OTHER _____
INSTRUCTION GIVEN TO _____
PROFESSIONAL SIGNATURE/TITLE _____ DATE _____
FOR RECURRING HOME CARE NEEDS OR QUESTIONS, CALL _____

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOU.

ORIGINAL-PATIENT YELLOW- PATIENT CHART

DISCHARGE INSTRUCTIONS

INSTRUCCIONES AL DARLE DE ALTA

Date of Discharge *(Fecha de Alta)* _____/_____/_____

We are pleased to have provided service to you. The following discharge instructions were reviewed with you and/or your caregiver(s) during the final visit(s) by organization staff. You are to:
Nos agradó haberle proveido servicios. Las siguientes instrucciones fueron revisadas con usted o su guardian:

☐ Keep your scheduled appointment with Dr. */Mantenga sus visitas al Dr.*_____
Day/*Día*_____ Date *(Fecha)* _____/_____/_____ Time *(Hora)* _____

☐ Continue to take medications as prescribed by your physician. *(tome las medicinas como le indicaron)*
☐ Instructions attached *(vea las instrucciones adjuntas)*
☐ Additional comments/instructions: *(Instrucciones adicionales)* _____
_____
_____

☐ Continue with home program as instructed by therapist. *(Continue con el programa indicado por el terapista)*
☐ Instructions attached *(vea las instrucciones adjuntas)*
☐ Additional comments/instructions: *(Instrucciones adicionales)* _____
_____
_____

☐ Follow the diet as prescribed by your physician and instructed by your nurse/dietitian. *(siga la Dieta prescrita)*

☐ Continue with skin/wound care as instructed by your nurse. *(continue cuidando su piel/herida)*
☐ Instructions attached *(vea las instrucciones adjuntas)*
☐ Additional comments/instructions: *(Instrucciones adicionales)* _____
_____
_____

☐ Follow through with community resource or other organization to which you have been referred (describe):
Siga con el servicio de los recursos de la comunidad u organización al cual fue referido:
_____
_____

☐ Other instructions (describe): *(Otras instrucciones)* _____
_____
_____

If you have questions concerning these instructions, please call your care manager at *(Si tiene preguntas llámenos)* (_____) _____. We hope that if you have need for home care in the future; you will contact us. *Esperamos que si tiene necesidad de cuidado de la salud a domicilio en el futuro nos llame.*

Care Manager Signature/Title _____ Date _____/_____/_____

PART 1 – Clinical Record	**PART 2 – Patient/Client**
PATIENT/CLIENT NAME – Last, First, Middle Initial	ID#

ALONDRA HOME HELP, LLC.

Discharge Instruction Sheet/*Instrucciones Al Darlo De Alta*

Patient Name: _____ MR# _____
Nombre del Paciente

Physician's Name: _____ TELEPHONE: _____
Nombre del Médico *Teléfono*

Date of Discharge _____ Receiving Facility: _____
Fecha de Alta *Facilidad de traslado*

Medications to be Continued/*Medicinas Que Debe Seguir Tomando*

Name of Medication *Medicinas*	Meds Schedule *Horario*	Possible Side Effects *Efectos posibles*	TX Given *Tratamiento*

Activities/*Actividades*

_____
_____

Wound Care/*Cuidado de heridas/úlceras*

_____
_____

Diet Instructions/*Intruciones para la Dieta*

_____
_____

Special Instructions/ *Instrucciones Especiales*

_____
_____
_____
_____

Nursing Signature/*Firma Enfermera*: _____ Date/*Fecha*: _____

GENTLE CARE Inc.

DISCHARGE SUMMARY

Patient:_____ MR#:_____
Start of Care Date: _____ D/C Date: _____
Physician notified of Discharge: __ YES __ NO., Reason: _____
Primary Diagnosis: _____
Status on Admission:

_____
_____
_____

Services Provided: __ SN ___ HHA ___ MSW ___Other(specify)_____

Status Upon Discharge:

Goals:	Status upon Discharge
#1: _____	___Met ___Not Met ___ Partially Met
#2: _____	___Met ___ Not Met ___ Partially Met
#3: _____	___Met ___ Not Met ___ Partially Met
#4: _____	___Met ___ Not Met ___ Partially Met

Reason Goal(s) partially/not met:

_____
_____

Instructions provided:

___ Safety/Emergency Procedures ___Disease process
___ Meds: Actions/S/E; specifically: _____
___ S/S of Complications requiring medical attention
Patient/care giver response to teaching:

_____
_____

Condition/Status upon D/C: ___ Stable ___ Unstable ___ Expired
Psychosocial status at D/C: ___ Oriented ___ Disoriented ___ Forgetful ___ Alert
___ Alert ___ Depressed ___ Agitated ___ Lethargic
____ Judgement: ___ Good ___ Fair ___ Poor
____ Perception: ___ Good ___ Fair ___ Poor
Adjustment to illness/disability: ___ Yes ___ No: Comments. _____
Support system: _____
Community Referrals: ___ No ___ Yes; specify: _____

_____

- -

Signature/Title of Person Completing form _____Date_____

cc: ___ Physician ____ Other: _____

GENTLE CARE Inc.

MEDICARE DISCHARGE CHART AUDIT FORM

PATIENT NAME:			MR#		
DOCUMENT	YES	NO	N/A	FIXED	**COMMENTS**
REFERRAL COMPLETE					
AGREEMENT (SIGNED/DATED)					
EMERGENCY PLAN (COMPLETED)					
MSP SIGNED/ DATED					
MECCA					
POC (SIGNED/DATED/RETURNED)					
MOD SIGNED/DATED					
MED UPDATE SIGNED QMOD/QMONTH					
MIED SHEET SIGNED/DATED					
NURSES NOTES SIGNED					
SOC OASIS COMPLETED					
TRANSFER OASIS					
RESUMPTION OF CARE OASIS					
HHA NOTES COMPLETED/SIGNED					
HHA CARE PLAN					
SUPERVISORY VISIT					
PHYSICAL THERAPY EVAL/OASIS					
PHYSICAL THERAPY NOTES					
PHYSICAL THERAPY DISCHARGE					
OASIS DISCHARGE					

1 - SIGNATURE DATE OF AUDIT

2. SIGNATURE/DATE OF AUDIT

3. SIGNATURE/DATE OF AUDIT

Tender Care Home Health Services, Corp.

NURSING DISCHARGE SUMMARY AND NOTE

☐ Visit Made
☐ No Visit

Patient: _____ To: Dr. _____
ID #- _____ HIC#: _____ Address: _____
SOC: _____ First Visit: _____ City: _____ Zip: _____
D/C Date: _____ ☐ Complete or ☐ Partial - Continued Service _____
Reason for Discharge: _____
Number of Visits: SN:_____ AIDE:_____ PT:_____ OT:_____ SLP:_____ MSS:_____ NUTR: _____
Diagnosis: _____

IF NO VISIT IS MADE, DOCUMENT LAST S/N ASSESSMENT VISIT FINDINGS:
DISCHARGE ASSESSMENT STATUS

T: _____ P:_____ R: _____ B/P: _____
Mental/Emotional: _____ Skin: _____
EENT: _____ Cardiac: _____
Edema: _____ Respiratory: _____
GI: _____ GU:_____
Nutritional: _____ Neuro: _____
Musculoskeletal: _____ Mobility: _____ Level: _____
Knowledge of level of:
Disease Process: _____ Medicine Schedule: _____
Medication S/E + actions: _____ Treatments: _____
Care Management: _____ Safety: _____
Other: _____

Reason for Admission: _____

Summary of Care Provided: _____

Condition at Discharge: _____

NEW PROBLEMS IDENTIFIED AFTER START OF CARE: _____

SELF CARE ACTIVITY ON ADMISSION: _____
At D/C: ☐ Self care resumed or ☐ Assist to be provided by _____ or ☐ Transferred to _____
CARE PROVIDED: ☐ Observation/Evaluation ☐ Instruction ☐ Personal Care as Ordered ☐ Treatments as needed
☐ Other _____
GOALS MET: ☐ Yes ☐ No If no explain why _____

INSTRUCTIONS FOR CONTINUING CARE NEEDS: ☐ Physician Follow-up ☐ Medication ☐ Biomedical Waste
☐ Equipment ☐ Other _____
ADDITIONAL COMMENTS/Referrals Made: _____

Physician contacted on _____ and discharged is approved.

RN Signature: _____ Date: _____

Original: Clinical Record **Yellow: Physician**

PREMIUM HOME HEALTH CARE, INC

4960 SW 72nd Ave. Suite 302
Miami, Fl. 33155
Office: 786-268-4320
Fax: 786-268-4311

Physician Name: _____
Physician Address: _____

Physician Phone: _____

DISCHARGE ORDER

Patient Name: _____ MR #: _____
Patient Address: _____
Diagnosis: _____
Date Effective: _____

DISCHARGE PATIENT FROM HOME HEALTH SERVICES TODAY ☐

DISCHARGE THE FOLLOWING DISCIPLINE AND PATIENT WILL CONTINUE WITH HOME HEALTH SERVICES ☐

Skilled Nurse ☐ Aide ☐ Physical Therapy ☐ Occupational Therapy ☐
Speech Therapy ☐ Medical Social Worker ☐ Respiratory Therapy ☐

_____
_____
_____
_____

REASON FOR DISCHARGE

Goals Met ☐ Patient Refused Further Services ☐ Patient has moved out of geographical area ☐
Patient has expired ☐ Hospitalization ☐ Physician Cancelled Services ☐
Transferred to Another Agency ☐ Partial Discharge ☐ Other ☐

_____
_____
_____
_____

_____ _____
Signature of Nurse Receiving Orders Date

_____ _____
Physician Signature Date

Date Received: _____

ALONDRA
HOME HELP, LLC.

NURSING DISCHARGE SUMMARY / NOTE

PATIENT _____

MED REC #_____ ADM DATE _____ DISCH DATE _____

DIAGNOSIS *(Primary)* _____

DR. _____

ADDRESS _____

CITY, ZIP _____ TEL _____

SERVICES RENDERED: *Frequency on ADM to Discharge*

SN _____ H H A _____

MSW _____ ☐ DIETICIAN_____

REASON FOR DISCHARGE: _____

☐ PARTIAL - STILL RECEIVING SERVICES OF:

☐ PT ☐ ST ☐ OT ☐ HHA _____

☐ COMPLETE

CONDITION ON DISCHARGE:

☐ STABLE ☐ IMPROVED

☐ UNSTABLE ☐ DECEASED

DISPOSITION OF THE PATIENT:

☐ ABLE TO CARE FOR SELF ☐ FAMILY TO ASSIST

☐ INSTITUTIONALIZED ☐ HOMEMAKER TO ASSIST ☐ DECEASED

LAST M.D. VISIT:_____

LAB REPORTS _____

CHANGE ORDERS / NEW DIAGNOSIS:

☐ YES ☐ NO

RN CONTACTED PHYSICIAN ON DATE: _____ AND DISCHARGE IS APPROVED.

SUMMARIZE:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

☐ VERBALIZES KNOWLEDGE OF MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET. FLUIDS, DISEASE PROCESS, TREATMENT PROGRAM. S/S NECESSITATING MEDICAL ATTENTION.

☐ RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS.

☐ HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.

☐ PRESENTING SYMPTOMS ABSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION.

☐ INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS.

☐ MAXIMUM POTENTIAL OF SKILLED SERVICES ATTAINED WITHIN HOME SETTING.

SKILLED OBSERVATION / ASSESSMENT ON DISCHARGE

DISCHARGED V/S _____

VITAL SIGNS RANGE:

BP _____ TO _____

AP _____ TO _____

RR _____ TO _____

TEMP _____ TO _____

GU/GI:

VOIDING: INCONTINENT, NORMAL, FOLEY CATHETER

BOWELS: REGULATED, NOT REGULATED, OSTOMY, CATHARTIC REQUIRED

_____

_____

MENTAL STATUS:

☐ ALERT ☐ DISORIENTED

☐ FORGETFUL ☐ CONFUSED

ANXIOUS

DERMA:

TURGOR ☐ GOOD ☐ FAIR ☐ POOR

WOUND/DECUBITUS: ☐ HEALED ☐ NOT HEALED-PT/FAMILY DEMONSTRATES PROPER WOUND CARE

CARDIAC/CIRCULATORY:

☐ FREQUENCY OF CHEST PAIN

☐ FREE OF CHEST PAIN

☐ CONTROLLED ON MEDICATION

EDEMA: ☐ NONE ☐ TRACE ☐ MODE RATE ☐ PITTING ☐ NON-PITTING

NUTRITION:

DIET _____

☐ TUBE FEEDING ☐ TPN

APPETITE:

☐ GOOD ☐ FAIR ☐ POOR

PULMONARY:

LUNGS: ☐ CLEAR ☐ RONCHI ☐ IBS ☐ RALES ☐ WHEEZING

O2 ☐ REQUIRED ☐ NOT REQUIRED

ENDOCRINE:

DIABETES

☐ DIET CONTROLLED

☐ ORAL HYPOGLYCEMIC

☐ INSULIN DEPENDENT

EENT:

HEARING ☐ GOOD ☐ POOR

VISION ☐ GOOD ☐ POOR

PATIENT / FAMILY INSTRUCTED IN:

☐ POST CATARACT CARE
☐ INJECTION ADMINISTRATION
☐ DISEASE PROCESS
☐ S/S OF COMPLICATIONS
☐ ACTION/SIDE EFFECTS OF MEDS
☐ FOLEY CARE
☐ WOUND/DECUBITUS CARE
☐ CARE OF TERMINALLY ILL
☐ DIABETIC MANAGEMENT
☐ DIET/FLUID INTAKE
☐ OSTOMY/CONDUIT CARE
☐ SAFETY FACTORS
☐ ACTIVITY RESTRICTIONS
☐ ADMINISTRATION OF TUBE FEEDINGS
☐ ADMINISTRATION OF INHALATION RX
☐ IV THERAPY
☐ FIT. INDWELLING CATHETER CARE/PRECAUT.
☐ S/S COMPLICATIONS/INFECTION

PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: ☐ GOOD ☐ FAIR ☐ POOR ☐ REPETITIVE TEACHING REQUIRED

NURSING GOALS MET: ☐ YES ☐ NO .... IF NO, EXPLAIN _____

PATIENT/FAMILY GOALS MET: ☐ YES ☐ NO ... IF NO, EXPLAIN _____

ADDITIONAL COMMENTS AND INSTRUCTIONS: _____

RN SIGNATURE _____ DATE _____

SALUD HOME CARE

DISCHARGE IN OFFICE/AGENCY

Patient's Name: _____ MR #: _____

Date of Discharge: _____ Report date to MD: _____

Other Patient identifying information (Medicare, Medicaid, Insurance): _____

_____

Patient's physician and phone number: _____

_____

Patient's Status at Discharge: _____

_____

Name/Title of person making report: _____

Primary Diagnosis: _____

_____

Reason for Discharge: ☐ Dead at Home ☐ Move out from area of services: _____

☐ Transfer to an in-patient facility: _____

☐ Other, explain: _____

A brief description of why was unable to complete the discharge assessment (OASIS, if applicable), services provided and ongoing needs that were not met::

_____
_____
_____
_____
_____
_____

_____ _____

Signature & Title of Staff making report Date

☐ Copy faxed to Patient's Physician

Q.A. Nursing Services, Corp.

M.R.# _____

OT DISCHARGE/TRANSFER SUMMARY

PATIENT NAME _____

Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____
Date of Last Billable Visit: _____/_____/_____
Diagnosis (Primary) _____

DR. _____
Address: _____

Tel. No. ( )

SERVICES RENDERED: Total # of actual visits

RN _____ HHA _____
PT _____ OT/ST _____
MSW _____ Other _____

REASON FOR DISCHARGE _____

☐ Partial - still receiving services of RN, PT, ST, OT, HHA

☐ Complete

CONDITION ON DISCHARGE:

___ Stable ____ Improved
___ Unstable ____ Deceased

DISPOSITION OF THE PATIENT:

____ Able to care for self
____ Institutionalized
____ Family to assist
____ Homemaker to assist ____ Deceased
____ Other: _____

RN/PT/OT/ST contacted physician on _____/_____/_____ and discharged is approved.

SUMMARIES:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:

___ Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention.
___ Return to previous lifestyle with modification within disease limitations.
___ Independence in self care within disease limitation
____ Home free of hazards using proper safety
____ Presenting symptoms absent and/or controlled by appropriate intervention
____ Maximum potential attained within home setting.

On Discharge:	VITAL SIGNS	Vital Signs Range
_____	TEMPERATURE	_____ TO _____
_____	PULSE	_____ TO _____
_____	RESPIRATION	_____ TO _____
_____/_____	BLOOD PRESSURE	____/____ TO ____/____

PATIENT/FAMILY INSTRUCTED IN:

☐ Post cataract care	☐ Wound/Decubitus Care	☐ Activity Restrictions
☐ Injection Administration	☐ Diabetic Management	☐ Administration of Tube Feedings
☐ Disease Process	☐ Diet/Fluid Intake	☐ Administration of Inhalation Rx
☐ S/S of complications	☐ Ostomy/Conduit Care	☐ IV Therapy
☐ Action/Side effects of Medications	☐ Safety Factors	☐ Indwelling Catheter Care/Precaut.
	☐ Foley Care	☐ S/S Complications/Infection

Patient/Family response and adherence to teachings: ____ Good ____ Fair ____ Poor ____ Repetitive teaching required
Goals Met: ____ Yes ____ No If No, explain _____
Patient/Family Goals Met: ____ Yes ____ No If No, explain _____

Employee's Signature: _____ Title _____ Date _____/_____/_____

HOME HEALTH

ACHC ACCREDITED

THERAPY DISCHARGE SUMMARY / NOTE

PATIENT _____ DR. _____

MED REC. # _____ ADM DATE _____ DISCH DATE _____ ADDRESS _____

DIAGNOSIS: (PRIMARY) _____ CITY, ZIP _____ TEL. _____

SERVICES RENDERED: And # of visits per discipline

RN HHA MSW P.T. ST O.T.

REASON FOR DISCHARGE

- ☐ Hospitalized
- ☐ Moved From Area
- ☐ Refuse
- ☐ Skill Nursing
- ☐ Deceased
- ☐ Rehabilitated To Potential

CONDITION ON DISCHARGE:

☐ STABLE ☐ UNSTABLE ☐ DECEASED

DISPOSITION OF THE PATIENT:

☐ ABLE TO CARE FOR SELF ☐ FAMILY TO ASSIST ☐ BOARDING HOME/ACLF

PHYSICIAN CONTACTED ON DATE: _____ AND DISCHARGE IS APPROVED

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

- ☐ VERBALIZES KNOWLEDGE OF DISEASE PROCESS. TREATMENT PROGRAM, S/S NECESSITATING MEDICAL ATTENTION.
- ☐ RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS.
- ☐ HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.
- ☐ ADMITTING SYMPTOMS ASSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION.
- ☐ INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS
- ☐ MAXIMUM POTENTIAL ATTAINED WITHIN HOME SETTING.

SKILLED OBSERVATION I ASSESSMENT ON DISCHARGE

MENTAL STATUS

- ☐ ALERT
- ☐ FORGETFUL
- ☐ ANXIOUS
- ☐ DISORIENTED
- ☐ CONFUSED

Current Functional Limitations: Code I- Independent, A - Assistance, U - Unable.

- ☐ **Supine To Sit**
- ☐ **Transfers:**
- ☐ **Ambulation On:**
- ☐ **Sitting Balance**
- ☐ **Balance to Chair**
- ☐ **Levels** ☐ **Stairs**
- ☐ **Sit To Read**
- ☐ **Chair To Toilet**
- ☐ **Ramp**
- ☐ **Standing Balance**
- ☐ **Chair To Car**
- ☐ **Wheelchair**
- ☐ **Chair To Bathtub**

 # Ft: _____ **Device:** _____

PATIENT / FAMILY INSTRUCTED IN:

- ☐ DISEASE PROCESS
- ☐ S/S OF COMPLICATIONS
- ☐ HEP
- ☐ ACTIVITY RESTRICTIONS
- ☐ S/S COMPLICATIONS
- ☐ SAFETY FACTORS

PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: ☐ GOOD ☐ FAIR ☐ POOR ☐ REPETITIVE TEACHING REQUIRED

THERAPY: GOALS MET: ☐ YES ☐ NO ... IF NO, EXPLAIN _____

Patient/Family GOALS MET: ☐ YES ☐ NO ... IF NO, EXPLAIN _____

ADDITIONAL COMMENTS AND INSTRUCTIONS: _____

THERAPIST PRINT NAME/TITLE: _____

THERAPIST SIGNATURE/TITLE: _____

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME | FIRST NAME | PATIENT #

TYPE OF DISCHARGE: ☐ COMPLETE ☐ PARTIAL - STILL RECEIVING SERVICES OF: ☐ PT ☐ ST ☐ OT ☐ HHA ☐ SN

ADM DATE _____ **DISCH DATE** _____ DR _____

DIAGNOSIS (PRIMARY) _____ ADDRESS _____

_____ CITY, ST _____ ZIP _____

VISITS RENDERED BY: _____ RN _____ HHA _____ PT _____ OT _____ ST _____ Msw

REASON FOR DISCHARGE:
☐ GOALS MET ☐ MOVED OUT OF AREA ☐ OTHER
☐ HOSPITALIZATION ☐ PATIENT EXPIRED
☐ SKILLED NURSING FACILITY ☐ CARE REFUSED
☐ TRANSFER TO ANOTHER AGENCY ☐ SKILLED CARE NO LONGER NEEDED

DISPOSITION ☐ SELF CARE ☐ NH ☐ ACLF ☐ FAMILY CARE ☐ OTHER

CONDITION ☐ IMPROVED ☐ STABLE ☐ UNSTABLE ☐ DECEASED ☐ REGRESSED

DEPENDENCY ☐ DEPENDENT ☐ INDEPENDENT ☐ REQUIRES SUPERVISION/ASSIST

EXERCISES ☐ PASSIVE ☐ ACTIVE ☐ ACTIVE ASSISTIVE ☐ RESISTIVE

PERFORMED WITH: ☐ R.U.E. ☐ R.L.E. ☐ L.U.E. ☐ L.L.E. ☐ TRUNK ☐ NECK

TRANSFER ACTIVITIES: ☐ HOYER LIFT ☐ CRUTCHES ☐ WALKER ☐ W/C ☐ CANE ☐ QUAD CANE ☐ OTHER _____

GAIT TRAINING: ☐ N.W.B. ☐ P.W.B. ☐ F.W.B. ☐ EVEN SURFACES ☐ STAIRS ☐ UNEVEN SURFACES

ASSISTANCE REQUIRED: ☐ MAXIMUM ☐ MINIMUM ☐ MODERATE ☐ GUARDING ☐ OTHER _____

DISTANCE AMBULATED: ☐ 20 ft. ☐ 40 ft. ☐ 60 ft. ☐ 80 ft. ☐ 100 ft. ☐ 120 ft.

INSTRUCTED ON HOME PROGRAM: ☐ PATIENT ☐ SIGNIFICANT OTHER ☐ FAMILY

NARRATIVE: _____

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy
_____ PATIENT HAS ACHIEVED ANTICIPATED GOALS
_____ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
_____ ABSENCE OF PAIN
_____ FREE OF CONTRACTURES
_____ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
_____ DEMONSTRATES RANGE OF MOTION EXERCISES
_____ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
_____ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
_____ AMBULATES SAFELY WITH ASSISTIVE DEVICE
_____ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

Speech Therapy
_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
_____ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

_____ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
_____ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
_____ HEALED INCISION
_____ DEMONSTRATES STUMP WRAPPING AND HYGIENE
_____ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
_____ DESCRIBES PHANTOM LIMB SENSATION
_____ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Occupational Therapy
_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
_____ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
_____ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR

THERAPY GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

PATIENT/S.O.GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

COMMENTS: _____

☐ PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. ☐ M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE _____ DATE _____

Q.A. Nursing Services, Corp.

M.R.# _____

SPEECH THERAPY DISCHARGE/TRANSFER SUMMARY

PATIENT NAME _____

Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____
Date of Last Billable Visit: _____/_____/_____
Diagnosis (Primary) _____

DR. _____
Address: _____

Tel. No. ( )

SERVICES RENDERED: Total # of actual visits

SN _____ HHA _____
PT _____ OT _____
MSW _____ ST _____

REASON FOR DISCHARGE _____

☐ Partial - still receiving services of RN, PT, MSW, OT, HHA

☐ Complete ☐ Transfer to:

CONDITION ON DISCHARGE:

___ Stable ____ Improved
___ Unstable ____ Deceased

DISPOSITION OF THE PATIENT:

____ Able to care for self ____ Family to assist
____ Institutionalized ____ Homemaker to assist ____ Deceased
____ Other: _____

Speech therapist contacted physician on _____/_____/_____ and discharged is approved.

SUMMARIES:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:

___ Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention.
___ Return to previous lifestyle with modification within disease limitations.
___ Independence in self care within disease limitation
____ Home free of hazards using proper safety
____ Presenting symptoms absent and/or controlled by appropriate intervention
____ Maximum potential attained within home setting.

STATUS AT DISCHARGE:

☐ Voice disorders: _____
☐ Speech articulation disorders: _____
☐ Dysphagia: _____
☐ S/S of complications:

☐ Language disorders: _____
☐ Aural rehabilitation: _____
☐ Non oral communication: _____
☐ Alaryngeal speech skills: _____

☐ Safe swallowing evaluation: _____
☐ Lip, tongue facial exercise: _____
☐ Pain management: _____
☐ Speech dysphagia: _____

PATIENT/FAMILY INSTRUCTED IN:

☐ Physician follow visits
☐ Home lip, facial, tongue exercises program
☐ Disease Process
☐ S/S of complications
☐ Action/Side effects of Medications
☐ Care of voice prosthesis
☐ Develop communication system
☐ Diet/Fluid Intake
☐ Food texture recommendations
☐ Safety Factors
☐ Improve swallowing/vocal skills
☐ Activity Restrictions
☐ Rehabilitation program
☐ Home maintenance program
☐ Family/caregiver education
☐ Voice disorders
☐ Emergency Plan

Patient/Family response and adherence to teachings: ____ Good ____ Fair ____ Poor ____ Repetitive teaching required
Goals Met: ____ Yes ____ No If No, explain _____
Patient/Family Goals Met: ____ Yes ____ No If No, explain _____

Employee's Signature: _____ Title _____ Date _____/_____/_____

GENTLE CARE Inc.

☐ Visit made
☐ No visit

THERAPY DISCHARGE SUMMARY

PATIENT _____ TO: DR. _____

CR# _____ HIC# _____ ADDRESS _____

SOC _____ 1st VISIT _____ CITY _____ ZIP _____

D/C DATE _____ ☐ COMPLETE or ☐ PARTIAL – continued services _____

REASON FOR DISCHARGE: _____

NUMBER OF VISITS: PT _____ OT _____ SLP _____ MSS _____ AIDE _____

DIAGNOSES: _____

ADMISSION STATUS	**DISCHARGE STATUS**
Pain due to _____, level _____	Pain due to _____, level _____
ROM _____	ROM _____
Strength and Endurance _____	Str/End _____
Balance _____	Balance _____
Coordination _____	Coordination _____
Bed Mobility _____	Bed Mobility _____
Transfers _____	Transfers _____
Ambulation _____	Ambulation _____
Fine Motor Coordination _____	Fine Motor Coord _____
Sensory/ Perceptual Awareness _____	S/P Awareness _____
Sensory/Perceptual Coordination _____	S/P Coord _____
Receptive Communication _____	Receptive Com _____
Expressive Communication _____	Expressive Com _____
Swallowing _____	Swallowing _____
Knowledge level of	Knowledge level of
Disease Process _____	Disease Process _____
HEP _____	HEP _____
Treatments _____	Treatments _____
Care Management _____	Care Management _____
Safety _____	Safety _____
Other _____	Other _____
Other _____	Other _____

PROBLEMS IDENTIFIED AFTER START OF CARE: _____

SELF CARE ACTIVITY ON ADMISSION: _____

At d/c: ☐ Self Care resumed; or ☐ Assist to be provided by _____,
or ☐ Transferred to _____

CARE PROVIDED: ☐ Observation/Evaluation, ☐ Instruction, ☐ Personal care as ordered,
☐ Treatments as ordered, ☐ Other _____

UNMET NEEDS: _____

INSTRUCTIONS FOR CONTINUING CARE NEEDS: ☐ Equipment management, ☐ Physician follow-up,
☐ Home program, ☐ Other _____

ADDITIONAL COMMENTS/ Referrals made: _____

Physician contacted on _____ and discharge is approved.

Therapist Signature _____ Date _____

PHYSICAL THERAPY
DISCHARGE SUMMARY ADDENDUM

PHYSICAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ PATIENT DEMONSTRATED CORRECT BODY MECHANICS
- ❑ PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- ❑ ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.

CARE PLAN SHORT/LONG TERM GOALS REACHED:

GENERAL

- ❑ Gait increased tinetti gait score to _____ / 12
- ❑ Improved gait requiring ____ to _____ from _____ to _____

BED MOBILITY

- ❑ Pt. able to turn side (facing up) to lateral (left/right)
- ❑ Pt. able to lie back down
- ❑ Pt. able to sit up independently _____
- ❑ Pt. able to self reposition
- ❑ IMPROVED BED MOBILITY (INDEPENDENT)

BALANCE

- ❑ Increased tinetti balance score to _____/16
- ❑ Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance

TRANSFER

- ❑ Pt. able to transfer from _____ to _____ with/without assistance
- ❑ INDEPENDENT WITH TRANSFER SKILLS

STAIR/UNEVEN SURFACE

- ❑ Pt. able to climb stair/uneven surface with/without assistance _____ steps # _____

MUSCLE STRENGTH

- ❑ Pt. able to hold weigh _____ lb
- ❑ Pt. able to oppose flexion or extension force over _____

PAIN

- ❑ Pain decreased from _____/10 to _____ /10
- ❑ DEMONSTRATED EFFECTIVE PAIN MANAGEMENT
- ❑ PATIENT EXPERIENCED A DECREASE IN PAIN

ROM

- ❑ Pt. increased ROM of _____ by _____ degrees flexion/extension

SAFETY

- ❑ Pt. able to use _____ independently to _____ feet
- ❑ Pt. able to self propel wheel chair _____ feet
- ❑ Pt able to finalize and demonstrated to follow up HEP.

OTHER:

_____
_____
_____
_____
_____

ADDITIONAL SPECIFIC THERAPY GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ OT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ PTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date_____
Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#

UNLIMITED HOME CARE, INC.

OCCUPATIONAL THERAPY DISCHARGE SUMMARY ADDENDUM

OCCUPATIONAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ DEMONSTRATED PROPER USE OF PROSTHESIS/BRACE/SPLINT DEMONSTRATED PROPER USE OF DME/HME.
- ❑ PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN ADL'S, IADL'S.
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ORTHOTIC, SPLINTING AND/OR EQUIPMENT, ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN MUSCLE USE, MOTOR COORDINATION
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN NEURO RESPONSE
- ❑ DISCHARGE PLANNED DISCUSSED WITH PATIENT / FAMILY

CARE PLAN SHORT/LONG TERM GOALS REACHED:

- ❑ Patient able to finalize and demonstrate to follow up HEP.
- ❑ Pain level decreased from ____/10 to ____/10
- ❑ Pt. able to stand in kitchen to prepare meal for _____ min
- ❑ Patient able to reach _____ on _____
- ❑ Patient able to lift _____ # pounds from _____ to _____
- ❑ Patient able to wash _____
- ❑ Patient able to reach a Cup from _____ and taked to _____
- ❑ Patient able to integrate orthotic/prosthetic _____ to _____
- ❑ Patient independent with safety issues in _____
- ❑ Improved bathing skills, use to _____
- ❑ Patient retraining of cognitive, feeding, and perceptual skills
- ❑ Patient able to improve body image with _____
- ❑ Independent with muscle re-education

OTHER:

_____

_____

_____

- ❑ Increased strength ❑ R ❑ L Hands
- ❑ Increased coordination ❑ R ❑ L Hands
- ❑ Increased sensation ❑ R ❑ L Hands
- ❑ Increase Neuro response by _____
- ❑ Use of SPLINTING AND/OR EQUIPMENT independent
- ❑ Demonstrate Hands motion to WNL within

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL SPECIFIC OT GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ PT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ OTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____

Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#

SALUD HOME CARE

Discharge letter Notification to Patient/Family
(Spanish Translation in the Back)

Dear: _____

Please be advised that as of _____/_____/_____you have been discharged from our Home Health Care Agency. We have mailed you final discharge summary to your physician.

We hope that your care was of a more than satisfactory nature. Please complete the "Patient Survey" that is included in your patient package and return mail it to us.

We wish you will continue with good health. Please remember to take your medications as prescribed by your physician and to follow-up visit your visit your physician per his/her request.

Please call us should you need further or additional assistance.

Sincerely,

_____
Director of Nursing or Qualified Designee

_____
Date

Carta de Información de Alta al Paciente/Familía

Por favor, usted está siendo avisado(a) de que en la siguiente fecha ____/____/____ será dado de alta de nuestra Agencia de Cuidados de Salud en el Hogar. Nosotros le hemos enviado por correo a su médico el sumario de su alta final.

Esperamos que su cuidado haya sido más que satisfactorio. Por favor complete la "Encuesta del Paciente" incluido en los papeles dejados en su casa y retornarlo por correo a nosotros.

Nosotros deseamos que usted continúe con buena salud. Por favor, recuerde tomar sus medicamentos como han sido prescritos por su doctor y seguir todas las indicaciones de el/ella.

Por favor, llámenos si usted necesitara asistencia adicional.

Firmas

Patient Name: _____

Patient Identification Number: _____

Home Health Agency: Your AGency Name

Address: Agency Address
Miami, FL 33122

Phone Number: Agency Phone

Home Health Change of Care Notice (HHCCN)

Your home health care is changing

Starting on _____, your home health agency will change the items/services listed below.

What items/services are changing?	Reason for change

Why are you getting this notice?

○ **Your doctor/provider changed (or didn't renew) the order for your home care.** The home health agency must follow doctor/provider orders to give you care. If you don't agree with this change, discuss it with your home health agency or the doctor/provider who orders your home care.

○ **Your home health agency decided to stop giving you the items/services for the reasons listed above.** If you think you still need home care, you can look for care from a different home health agency if you have a valid order. For help finding a different home health agency, contact the doctor/provider who ordered your home care. If you get care from a different home health agency, you can ask it to bill Medicare.

Get help or more information

If you have questions about these changes, contact your home health agency and/or the doctor/provider who orders your home care. You can't appeal to Medicare about payment for the items/services listed above unless you get the items/services and a Medicare claim is filed.

Optional details:

Sign below to show you understand this notice

Return this signed notice to your home health agency in person or by mail to the address above.

○ Check here if you're signing as an Authorized Representative and make sure your name is legible or print your name, if not legible.

Signature of patient or Authorized Representative	Date

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.