Discharge / Transfer Summary

Patient Name:	Medical Record Number:	DOB: / /
Admission Date: / /	Discharge Date: / /	Transfer Facility Name:
Reason for Discharge:	☐Care Completed / Self Care ☐LTC ☐Hospice ☐Deceased ☐Non-Compliant ☐Patient Refused ☐Hospital ☐Physician Request ☐Other:	

Condition at Discharge

Physical / Psychosocial:

☐Independent ☐Relies on Caregiver / Family Member ☐Other:

Care Summary (interventions, progression)

Patient's Diagnosis:
Description of the Care / Service Provided:

☐Goals Met ☐Goals Not Met: Reason:
☐Continued Symptom Management Needs:

Outcomes

☐Goals Met ☐Stabilized ☐Improved Functional Status ☐Condition Improved ☐Improved Knowledge of Disease Processes ☐Lack of Progress ☐Deterioration of Status ☐Other:

Comments:

Resources Ongoing

Resource Information Given to Patient for Continuing Needs: ☐ARxWP Patient Handbook ☐ARxWP Patient Education Checklist ☐Other:	Discharge Instructions: ☐Patient ☐Caregiver Able to Comprehend ☐Yes ☐No Comments:	Counseled to use Medical Follow-Up and PT/CG Verbalized Understanding ☐Yes ☐No
Special Instructions Given:		

Living Arrangements at Discharge

☐Own Home ☐Relatives Home ☐Other:

☐Discharge from Home Infusion Nursing	☐Physician Notified ☐Physician Provided Copy	☐Order and Summary Completed ☐Scheduler Notified
☐Report Given to Institution or Agency Assuming Care		

Patient's Prescriber:	Prescriber's Address:	Prescriber's Phone #:

Signature:	Title:	Date: