RED Discharge Preparation Workbook – Nursing Home to Community

Patient Name: _____

MRN: _____ DOB: _____

Room #: _____ Date of admission: _____

	Language Preference	Interpreter/Translation Needed (Y/N)
Spoken communication		
Written materials		
Phone communication		

Living Arrangement Description

	Description
Environment (home, apartment, with family, assisted living, homeless, etc.)	
Setting Description (stairs to enter or inside, railings, wheelchair accessibility, heat, cooking facilities, etc.)	

Existing or Recent Home Services and/or ASAP

Agency Name	Location	Phone Number

Existing DME at Home

Type	DME Company	Phone Number

Caregivers - Names	Phone Number	Language preference	Interpreter/ Translation Needed (Y/N)	Role (Food prep, mobility, meds, shopping, all)

1. Diagnoses

Admitting Dx: _____

Comorbidities: _____

Discharge Dxs _____

Patient/Caregiver needs information on diagnoses: Yes ____ No ____

2. Follow-up Appointments

PCP Appointment: _____

Patient has PCP? If NO, Preferences (gender, location)? _____

Patient requests for PCP appt (Weekdays, Time of day): _____

PCP Name	Day / Date / Time
Clinician to see at appt (if not PCP)	**Location**
	Address/Floor: **Phone #:** **Fax #:**

Does patient have transportation to PCP appointment? Yes ____ No ____

Transportation options discussed: _____

Additional Appointments, Tests, or Lab Work to be done POST DISCHARGE:

_____

Day / Date / Time	Telephone and Fax Number	Reason / Test / Lab
	T: **F**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Telephone and Fax Number	Reason / Test / Lab
	T: **F**:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Telephone and Fax Number	Reason / Test / Lab
	T: F:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Telephone and Fax Number	Reason / Test / Lab
	T: F:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

Day / Date / Time	Telephone and Fax Number	Reason / Test / Lab
	T: F:	
Provider	**Location (Address, floor)**	
How patient will get to appointment		

3. Medicine

Allergies _____ No known allergies _____

Allergy	Patient Confirm (Y/N)	If No, Explain	Allergy	Patient Confirm (Y/N)	If No, Explain

Medicines reconciled with patient and medical team prior to final teaching?
Yes ____ No ____

4. Pharmacy

Community Pharmacy Name	Phone #, Street Address, City

Who will fill Rx once discharged? Patient _____ Caregiver (Name)

_____

Number of days/supply prescriptions provided: _____

5. Diet and Nutrition

Discharge diet	

Patient/Caregiver needs diet instruction _____

Who will shop and prepare food? Patient _____ Caregiver (Name)

_____

6. Substance use

Substance	Patient Report	Current Tx. or Interested in Cessation Info?
Alcohol		
Tobacco		

7. Durable medical equipment or supplies needed at home?

Yes ____ No ____

New durable medical equipment ordered: Yes ____ No ____

Type _____

Company name: _____ **Contact:** _____

Address: _____ **Phone:** _____

Delivery Date: _____

Type _____

Company name: _____ **Contact:** _____

Address: _____ **Phone:** _____

Delivery Date: _____

8. Home care services needed at home?

Yes ____ No ____

Service _____

Company name: _____ **Contact:** _____

Address: _____ **Phone:** _____

Delivery Scheduled: _____

Service _____

Company name: _____ **Contact:** _____

Address: _____ **Phone:** _____

Delivery Scheduled: _____

Referral to Aging Services Access Point (ASAP) and Visiting Nurses Associations

Service _____

Company name: _____ **Contact:** _____

Address: _____ **Phone:** _____

Delivery Scheduled: _____

9. Outstanding Tests/Labs

Tests/Labs Pending	Date Conducted	Results Expected	Who Will Follow Up on the Result

10. Patient Teaching for Discharge

Date	Outstanding Patient Teaching/Information	Date Return Demo Satisfactory - Initials

11. After Nursing Home Care Plan (ACP) completed?

Yes ____ Date ____ Initials ____

Final ACP given and reviewed with patient? Yes ____ Date_____ Initials____

- **Reviewed what to do about problems? Yes ____ No ____**
- **Patient/caregiver understanding confirmed? Yes ____ No ____**
- **Patient/caregiver aware to expect follow-up phone calls? Yes ____ No ____**
- **Prescriptions and Meds provided? Yes ____ No ____**