Aven Home Health Services

DISCHARGE/TRANSFER TO FACILITY

Patient Name: _____ MR#: _____

Diagnosis: _____Date:_____ Time In: _____Time Out: _____

Discipline Completing:	**Other Discipline(s) Remaining:**
□ RN □ PT □ OT □ ST □ MSW □ RD	□ None □ RN □ PT □ OT □ ST □ MSW □ CHHA □ RD

*If Final Note previous to today's date check here: □ **N/A** Date of last/most recent home visit_____

REASON FOR: □ **DISCHARGE** □ **TRANSFER:**

□ Admission to Hospital, SNF, ICF _____
□ Patient and/or Family Assumed Responsibility
□ Patient Moved Out of the Area □ Patient Refused Services
□ Transferred to other HHA/Hospice _____
□ Transferred to an inpatient facility, patient is discharged from Agency.
Name/Type of Facility (if known): _____
□ Transferred to an inpatient facility, patient is NOT discharged from Agency.
Name/Type of Facility (if known): _____
□ Transferred to OP Rehab □ Death/Date_____
□ Other: _____

Initiated By:
□ Family □ Agency □ MD □ No Further Care Needed □Other

Notification of □DISCHARGE □TRANSFER: □ To MD □ To PT/FM/CG
Discharge Plan: □ Home with MD's Supervision □ Other: _____
Remaining Community Services/Agency/Facility: _____

Reason for Hospitalization:	
□ Improper medication administration, medication side effects, toxicity, anaphylaxis	□ Exacerbation of CHF, fluid overload, heart failure
□ Injury caused by fall or accident at home	□ Myocardial infraction, stroke
□ Respiratory problems (SOB, infection, obstruction)	□ Chemotherapy
□ Wound or tube site infection, deteriorating wound status, new lesion/ulcer	□ Scheduled surgical procedure
□ Hypo/Hyperglycemia diabetes out of control	□ Urinary tract infection
□ GI bleeding, obstruction	□ IV catheter-related infection
	□ Deep vein thrombosis, pulmonary embolus
	□ Uncontrolled pain
	□ Psychotic episode
	□ Other: _____

Reason for Admission to Nursing Home:	**Overall Status of Patient at DISCHARGE /TRANSFER:**
□ Therapy Services	**Mobility:**
□ Respite Care	□ Independent □ Assisted
□ Hospice Care	**Mental Status:**
□ Permanent Placement	□ Oriented □ Comatose □ Forgetful
□ Unsafe for care at home	□ Depressed □ Disoriented □ Lethargic
□ Unknown	□ Agitated □ Other_____
□ Other: _____	

Continuing Level of In-home Care:
□ Attended/Caregiver □ Family □ Self □ Other_____

Medicare Non-Coverage of Services Notification Issued To Patient: ☐ Yes Date: _____ ☐ No ☐ N/A
Skilled Care Performed /Instructions: Vital Signs: T_____ P_____ R_____ B/P_____ WT_____

_____ _____
Nurse/Therapist Name/Title/Signature **Date**