Aven Home Health Services

Phone: 818 380 0853 **Fax: 818 380 0143**

DISCHARGE SUMMARY

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

SKILLED CARE PERFORMED/INSTRUCTIONS *If Final Note previous to today's date check here: □ **N/A**

Vital Signs: T_____P_____R_____B/P_____WT_____

REASON FOR DISCHARGE:

Initiated By:

□ Family □ Agency □ MD □ No Further Care Needed □Other

□ Admission to Hospital, SNF, ICF _____ □ Family Moved Out of Area

□ Other: _____ □ Patient and/or Family Assumed Responsibility

□ Patient Moved Out of the Area □ Patient Refused Services

□ Transferred to other HHA/Hospice _____

□ Transferred to OP Rehab □ Death/Date_____

NOTIFICATION OF DISCHARGE: □ To MD □ To PT/FM/CG

DISCHARGE PLAN: □ Home with MD's Supervision □ Other: _____

REMAINING COMMUNITY SERVICES/AGENCY/FACILITY: _____

Problems Identified:	**Current Status of Problems:**
1._____	**1.**_____
2. _____	**2.** _____
3._____	**3.**_____
4._____	**4.**_____
5._____	**5.**_____

OVERALL STATUS OF PATIENT AT DISCHARGE:

Mobility: **Mental Status:**

□ Independent □ Oriented □ Comatose □ Forgetful □ Depressed

□ Assisted □ Disoriented □ Lethargic □ Agitated □ Other_____

Continuing Level of In-home Care:

□ Attended/Caregiver □ Family □ Self □ Other_____

SUMMARY OF CARE PROVIDED:

_____ _____

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