SHERIDAN MEMORIAL HOSPITAL ASSOCIATION

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DISCHARGE PLANNING ASSESSMENT
Case Management Department

Patient Name: _____

Physician Name: _____ Phone#: _____

Contact Person: _____ Relationship: _____

Phone #: _____ Admit Date: _____

Admit Diagnosis: _____

Working Diagnosis: _____

Pertinent Information: _____

_____

_____

Procedure Performed: _____ Date: _____

Medical Coverage: ☐ Medicare ☐ Medicaid ☐ Private: _____ ☐ Secondary
☐ HMO/PPO: _____ ☐ Medicare Adv: _____ ☐ None

Home Environment: ☐ Lives Alone ☐ Home with family/support ☐ Manor ☐ Skilled
☐ 1st Floor ☐ 2nd Floor _____ steps ☐ Assisted Living

Transportation: ☐ Auto ☐ Taxi ☐ Bus ☐Medi-Car ☐Ambulance ☐ Other: _____

Disability Issues: _____

Activities of Daily Living: ☐ Independent ☐ Supervised ☐ Limited ☐ Extensive ☐ Total

Bowel and Bladder: ☐ Continent ☐ Incontinent ☐ Dialysis ☐ Catheter ☐ Ostomy

Skin Integrity: ☐ Intact ☐ Rash ☐ Drains ☐ Wound ☐ Decubitus: Stage _____

Other: ☐ IVs ☐ Oxygen ☐ DME _____

Therapies Recommended: ☐ PT ☐ OT ☐ Speech ☐ Hydro ☐ Restorative

Education/Family Training: ☐ Performed ☐ Required ☐ Further training needed post-discharge

ADVANCED DIRECTIVES: _____

Discharge Planning Recommendations: _____

_____

_____

_____

Discharge Planner: _____ Discharge Date: _____

Discharge Code: _____ Organ Donor: ☐ Yes ☐ No

Patient/Resident: _____ Completed By: _____

1. Has patient been in this or any other facility before? ☐ Yes ☐ No

   If yes, Name: _____ Date: _____

2. Did patient live alone prior to hospitalization? ☐ Yes ☐ No

3. Did patient participate in placement decision? ☐ Yes ☐ No Agree to placement? ☐ Yes ☐ No

4. Please mark any of the following that the patient has with them or at home:

   ☐ Hospital Bed ☐ Lift or Geri Chair ☐ Wheelchair ☐ Bed side Commode

   ☐ Raised Toilet Seat ☐ Walker or Cane, Type: ☐ Rolling ☐ Standard

   ☐ Railings, Ramps, or Grab Bars ☐ Concentrator ☐ Nebulizer

5. What living arrangements are available at discharge (please mark one): ☐ None ☐ Uncertain

   ☐ Return to previous accommodations, which was: _____

   ☐ Other family member's or friend's home; their name: _____

   ☐ Assisted Living Center; name of center: _____

   ☐ Move to another level of care; where: _____

   ☐Other; explain: _____

6. Would patient be interested in Home Health Services? ☐ Yes ☐ No

7. Who will assist patient with discharge? Name:_____ Relationship: _____

8. What type of care giving would be available at time of discharge: (please mark one):

   ☐ Intermittent daily ☐ Intermittent weekly ☐ 24 Hour care ☐Uncertain

9. Please mark any structural accommodations already in place at anticipated discharge location:

   ☐ Outdoor-Indoor access ramp ☐ Bedroom Accommodations ☐ Bathroom Appliances

   ☐ Entrance Modifications ☐ Doorway Modifications ☐ Other: _____

10. Patient's Occupation(s): _____

11. Any evidence of: Dementia? ☐Yes ☐No Alzheimer's Disease? ☐Yes ☐No Parkinson's Disease? ☐Yes ☐No

12. Is the patient currently taking any psychotropic meds? ☐ Yes ☐ No

    ☐ Anti-psychotic ☐ Anti-depressant ☐Anti-anxiety

Interdisciplinary Patient Discharge Planning Record

Notes (include date/time, changes in discharge plan, initials of participants):

PATIENT:_____

COMMUNICATION CHECKLIST FOR DISCHARGE

_____Home, no service needed

_____Home, service needed

_____family support

_____Home Health

_____O2

_____Pals

_____PT

_____Other

EXTENDED CARE OPTIONS:

Suggestion: Level I on potential swing bed

_____Hi-Line Retirement Center

_____Hi-Line Assisted Living

_____Country Home

_____Pals/Private Pay/Respite

_____Hi-Line Apts/Home Health

____Hi-Line Apts/Private Pay

____Swing Bed: Admitting Criteria:_____

_____Public Health

Comments:

If 2 or more services are to be utilized-floor nurse/discharge planner need a scheduled meeting with the provider and all other entities.