INTERDISCIPLINARY SWING BED DISCHARGE SUMMARY

Resident Name: _____

Diagnosis: _____

_____

Check all areas that apply to this resident

B: Cognitive

Makes decisions:

☐ Independent ☐ Modified Independence

☐ Moderately Impaired ☐ Severely Impaired

Recent cognitive changes:

☐ No change ☐ Improved ☐ Deteriorated

Comments: _____

_____

_____

C: Communication and Hearing

☐ Hearing* 0 1 2 3 4 8

☐ Hearing Aid ☐ R ☐ L ☐ Both

Modes of speaking:

☐ Speech ☐ Writing ☐ Sign Language

Understood:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Speech:

☐ Clear ☐ Unclear ☐ No Speech

Understands:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ Vision* 0 1 2 3 4 8

☐ Visual Appliance ☐ Yes ☐ No

Comments:_____

_____

_____

E: Mood and Behavior

☐ Verbally Abusive (frequency _____)

☐ Physically Abusive (frequency _____)

☐ Alert ☐ Oriented (☐ Person ☐ Place ☐ Time)

☐ Depressed ☐ Disoriented (☐ Person ☐ Place ☐ Time)

☐ Wanders ☐ Comatose ☐ Semi-comatose

☐ Lethargic ☐ Resists Care ☐ Disruptive

☐ Physically/chemically restrained (frequency _____)

Comments:_____

_____

_____

F: Psychosocial

Support Services: _____

Comments: _____

_____

_____

G: Physical Functioning*

Bed Mobility	0	1	2	3	4	8
Transfer	0	1	2	3	4	8
Ambulation						
In room	0	1	2	3	4	8
In corridor	0	1	2	3	4	8
On unit	0	1	2	3	4	8
Dressing	0	1	2	3	4	8
Eating	0	1	2	3	4	8
Toilet Use	0	1	2	3	4	8
Grooming	0	1	2	3	4	8
Bathing	0	1	2	3	4	8

Mobility: ☐ walks (cane/walker) ☐ walks with help of _____

☐ wheels self ☐ is wheeled ☐ bed/chair confined ☐ bed confined

Functional limitations:

	No Loss	Partial Loss	Full Loss
Neck	☐	☐	☐
Rt. Arm	☐	☐	☐
Lt. Arm	☐	☐	☐
Rt. Hand	☐	☐	☐
Lt. Hand	☐	☐	☐
Rt. Leg	☐	☐	☐
Lt. Leg	☐	☐	☐
Rt. Foot	☐	☐	☐
Lt. Foot	☐	☐	☐
Other:	☐	☐	☐

Comments:_____

_____

_____

*0 = independence/adequate; 1 = supervision/impaired; 2 = limited assistance/moderately impaired; 3 = extensive assistance/highly impaired; 4 = dependent/severely impaired; 8 = did not occur

CHA COMMUNITY HOSPITAL OF ANACONDA

H: Continence Status

BOWEL		BLADDER
☐	continent	☐
☐	usually continent	☐
☐	occasionally continent	☐
☐	frequently continent	☐
☐	incontinent	☐

Catheter: ☐ Yes ☐ No Ostomy: ☐ Yes ☐ No
Comments: _____

J: Health Conditions/P: Treatment and Procedures

Problem Treatment

Pain (site, frequency, intensity) Treatment

Dressing Changes: _____
Type of dressing: _____
Frequency of change: _____
Site(s): _____
Accidents/Incidents: _____
Comments: _____

Participation level:
☐ Most ☐ Some ☐ Little ☐ None
Comments: _____

K: Oral/Nutritional

Weight: _____ Admission _____ Discharge
Height: _____ Ideal Body Weight: _____
Oral Problems:
☐ Chewing ☐ Swallowing ☐ Mouth Pain ☐ None
Dentures: ☐ Full ☐ Upper ☐ Lower
☐ Partial ☐ Upper ☐ Lower
☐ Own Teeth ☐ No Teeth
Supplements: _____
Diet: _____

K: Oral/Nutritional (continued)

Eating Habits/Normal Intake: _____
Comments: _____

M: Skin Conditions

☐ Dry ☐ Bruises easily
☐ Prone to Skin Tears ☐ No Skin Problem
Ulcer: ☐ Decubitus ☐ Stasis
Location: _____
Site: _____
Stage: _____
Protective Device: _____
Other Skin Conditions: _____
Comments: _____

N: Activities

Preferred Activities: _____
Comments: _____

O: Pertinent Medication/Drug Therapy

Q: Discharge

Plan: _____
Referral Made at Discharge: _____
Response to Stay: ☐ Markedly Improved ☐ Remained Stable
☐ Progress Slightly ☐ Did Not Improve ☐ Deteriorated
Plan discussed with Resident/Family: ☐ Yes ☐ No
Plan agreed upon by Resident/Family: ☐ Yes ☐ No
Comments: _____