Post Hospitalization Discharge Assessment Form

Person Served:_____ Location:_____

Admitting Diagnosis:_____

_____

Discharge Diagnosis:_____

_____

Discharge Physician:_____

Date of Admission:_____Date of Discharge:_____

Follow up Appointments:_____

Temperature:_____Pulse:_____ Respiration:_____Blood Pressure:_____

Lungs:_____

Heart:_____

Abdomen:_____

Skin:_____

Bladder/Bowel Continence:_____

Discharge Treatments:_____

Medication Changes:_____

Medications Ordered? Yes ☐ No ☐ When to arrive?_____

Can individual return to normal activity?

Day Program: Yes ☐ No ☐ If no, when?_____

Residential Program: Yes ☐ No ☐ If no, when?_____

Restrictions:_____

Special Arrangements (diets, medical, equipment, etc.)_____

_____

Staff Education/Training Needed: Yes ☐ No ☐ (if yes, indicate education needed)

_____

RN Name:_____ RN Signature_____

Date:_____ Time:_____