Post Hospitalization Discharge AssessmentForm

Person Served: _____

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: _____

Nursing Services Provided by **Dimensional Health Care Associates, Inc.**

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