ChecklistGuro

Patient Discharge Checklist: Care Transitions & Follow-Up

Discharge Planning & Assessment

Initial assessment and planning for patient's post-discharge needs.

Date of Initial Discharge Planning Meeting

Enter date...

Patient's Goals for Post-Discharge Recovery

Write something...

Patient's Living Situation Post-Discharge

- [ ] Home
- [ ] Assisted Living
- [ ] Skilled Nursing Facility
- [ ] Other

Number of Caregivers Available

Enter a number...

Summary of Patient and Family Concerns/Questions

Write something...

Patient's Understanding of Discharge Instructions

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Medication Reconciliation & Instructions

Ensuring accuracy of medication lists and providing clear instructions.

Patient Name

Write something...

Current Medication List (as reported by patient/family)

Write something...

Hospital/Facility Medication List

Write something...

Discharged Medication List (Name, Dosage, Frequency, Route)

Write something...

Medication Reconciliation Discrepancies?

- [ ] Yes
- [ ] No

Explanation of Discrepancies & Resolution

Write something...

Patient Understanding of Medications?

- [ ] Yes
- [ ] No
- [ ] Partially

Additional Instructions/Education Provided

Write something...

Follow-Up Appointments & Referrals

Scheduling necessary appointments and coordinating referrals.

Primary Care Physician Follow-Up Date

Enter date...

Specialist Appointment Date (e.g., Cardiology, Neurology)

Enter date...

Referral Needed?

- [ ] Yes
- [ ] No

Referral Specialty (if applicable)

- [ ] Cardiology
- [ ] Neurology
- [ ] Physical Therapy
- [ ] Other

Specialist Physician Name (if applicable)

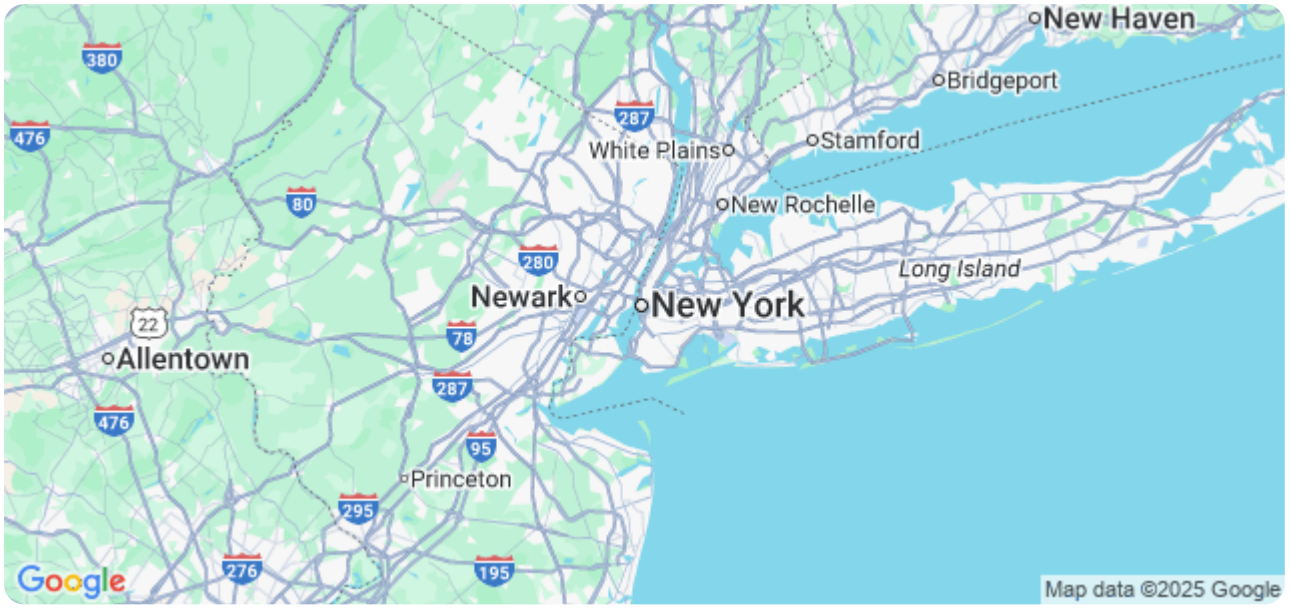
Write something...

Referral Notes/Instructions (for referring physician)

Write something...

Appointment Location (address)

Set My Current Location



Appointment Time

Home Health & Support Services

Arranging for any required home health or support services.

Home Health Agency Selected?

- [ ] Yes
- [ ] No
- [ ] Pending

Home Health Agency Contact Information

Write something...

Physical Therapy Required?

- [ ] Yes
- [ ] No
- [ ] Unsure

Estimated Home Health Visit Frequency (per week)

Enter a number...

Support Services Requested (check all that apply)

- [ ] Meals on Wheels
- [ ] Transportation Services
- [ ] Respite Care
- [ ] Social Worker Consultation
- [ ] Other (please specify in long text field)

Other Support Services Notes (if applicable)

Write something...

Patient & Family Education

Providing education on condition, recovery, and potential complications.

Explanation of Diagnosis & Condition

Write something...

Medication Instructions (Dosage, Timing, Side Effects)

Write something...

Potential Complications & Warning Signs

Write something...

Dietary Recommendations & Restrictions

Write something...

Received Instructions on Wound Care (if applicable)

- [ ] Yes
- [ ] No

Understanding of Follow-Up Appointment Schedule

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Patient Acknowledgement of Education

Discharge Documentation & Legal

Verifying all necessary documentation and addressing legal requirements.

Physician Signature

Date of Discharge Order

Enter date...

Advanced Directives Status

- [ ] Exists & Reviewed
- [ ] Exists & Not Reviewed
- [ ] Does Not Exist

Summary of Patient Concerns/Questions

Write something...

Relevant Legal Documents (if applicable)

Upload File

HIPAA Acknowledgement

- [ ] Patient Acknowledges HIPAA Rights
- [ ] Patient Unable to Acknowledge

Equipment & Supplies

Ensuring patient has necessary equipment and supplies for home.

Needed Durable Medical Equipment (DME)

- [ ] Walker
- [ ] Crutches
- [ ] Wheelchair
- [ ] Hospital Bed
- [ ] Oxygen Concentrator
- [ ] Other (Specify Below)

Other DME Specifications (If selected above)

Write something...

Quantity of Wound Care Supplies

Enter a number...

Prescription for Home Health Supplies (if applicable)

Upload File

Supplier for Equipment & Supplies

- [ ] Hospital Supplier
- [ ] Patient's Preferred Supplier
- [ ] Other (Specify Below)

Other Supplier Information

Write something...

Transportation & Logistics

Arranging transportation for patient’s departure from facility.

Mode of Transportation

- [ ] Ambulance
- [ ] Private Vehicle
- [ ] Public Transportation
- [ ] Hospital Transport
- [ ] Taxi/Ride-Sharing

Driver Name (if applicable)

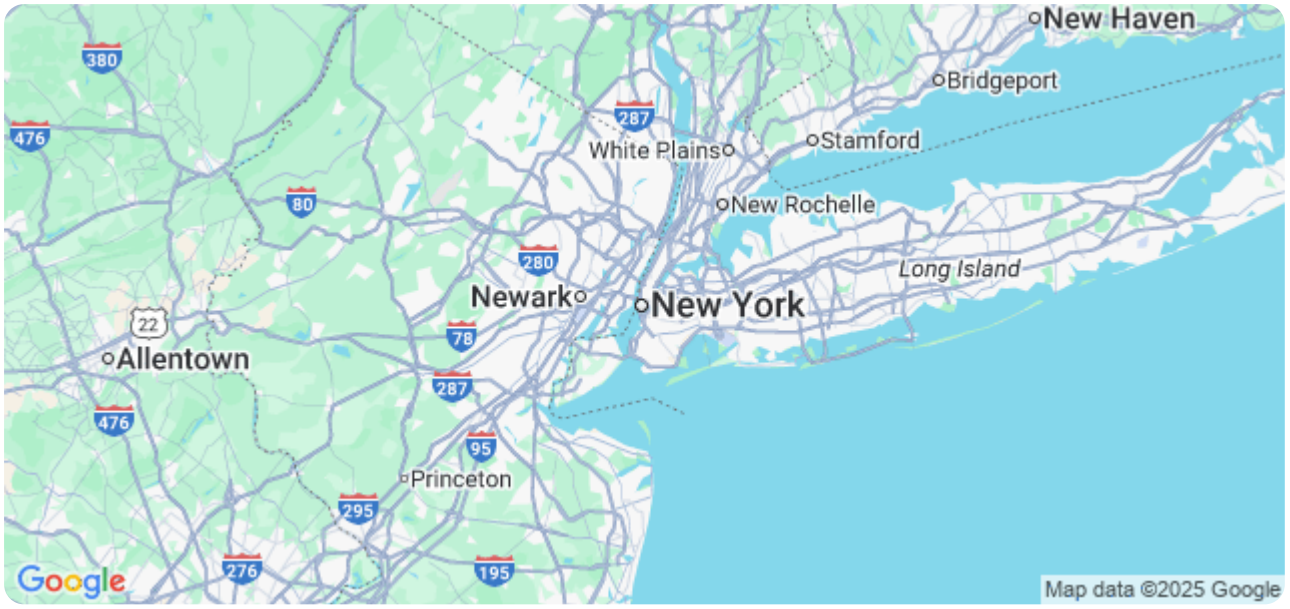
Write something...

Vehicle License Plate Number (if applicable)

Write something...

Destination Address

Set My Current Location



Scheduled Departure Time

Driver Signature (Confirmation)

Final Review & Sign-Off

Comprehensive review of all discharge steps and final sign-off by responsible parties.

Physician Signature

Nurse Signature

Case Manager Signature (if applicable)

Discharge Instructions Reviewed with Patient/Family?

- [ ] Yes
- [ ] No

Patient Identification Verification Score (1-10)

Enter a number...

Date of Final Review

Enter date...

Time of Final Review

Comments/Notes Regarding Final Review

Write something...