

Carelink Health Care Services, LLC

Discharge Notice

Agency Copy

Patient Name: _____ Date: _____

Physician: _____ MR# _____

Carelink Health Care Services, LLC will be discharging you from services on _____.

Reason for Discharge: ☐ Goals Met ☐ Hospitalized ☐ Other-See Below

If you have any questions or concerns please do not hesitate to contact our office.

629 E Wood Street Suite 201
Vineland, NJ 08360
856-691-7035

Date Discharge Notice Provided: _____

Method Discharge Notice Provided ☐ Mailed ☐ Hand Delivered

If Mailed, Date Mailed: _____

Nurse Signature: _____ Date: _____

Please contact Carelink Health Care Services, LLC for further health care needs.

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Carelink Health Care Services, LLC

Discharge Assessment

Patient Name: _____ Date: _____

Physician: _____ MR# _____

Date of Discharge: _____ Date Discharge Notice Provided: _____

Reason for Discharge: ☐ Goals Met ☐ Death ☐ Hospitalized ☐ Other-See Below

Current Diagnosis:

Past History

Allergies: (environmental, drugs, food, etc.)

Vital Signs:

Temp. _____ Resp. _____ BP (designate position/s) _____

Pulse: Apical Rate _____ Radial Rate _____ Rhythm _____ Quality _____

Comments: _____

Life System Profile

5-WNL 4-Not Normal, but w/o help 3-Uses a device 2-With assistance 1-Device and help 0-Dependent

Activities of Daily Living (ADL)

- | | |
|------------------------------------|---------------------------------------|
| ☐ Bathing | ☐ Transferring |
| ☐ Dressing | ☐ Locomotion |
| ☐ Grooming | ☐ Eating |
| ☐ Toileting | ☐ Other |

Instrumental Activities of Daily Living (IDAL)

- | | |
|--|--|
| ☐ Telephone | ☐ Money management |
| ☐ Meal preparation | ☐ Shopping |
| ☐ Housework | ☐ Manage appointments |
| ☐ Laundry | ☐ Access resources |
| ☐ Medicine management | |

Homebound Status (✓ appropriate blanks)

- | |
|--|
| ☐ Outdoors without assistance |
| ☐ Outdoors with assistance |
| ☐ Confined to house, not bed disabled |
| ☐ Bed disabled |

Comments: _____

Financial/Legal (✓ appropriate blank)

- | |
|--|
| ☐ Independent |
| ☐ Needs assistance from _____ |
| ☐ Power of Attorney |
| ☐ Living Will |
| ☐ DNR discussed |

Comments: _____

Habits: (✓ and describe)

- | | | |
|-----------------------------------|---------------------------------------|---|
| ☐ Alcohol | ☐ Nicotine | ☐ Sleep disorder |
| ☐ Caffeine | ☐ Street Drugs | ☐ Other |

Comments: _____

Carelink Health Care Services, LLC

Discharge Assessment

Physical Environment: (✓ appropriate blanks)

- | | | |
|---|--|---|
| ☐ All Adequate | ☐ Interior safety hazards | ☐ Transportation inadequate |
| ☐ Inadequate space | ☐ Structural hazards | ☐ Private water supply/sewage disposal problem |
| ☐ Stairs | ☐ Electrical/fire hazards | |

Comments: _____

Psycho-Social Profile: No ☐ problems (leave blank) S-subjective problem D-objectively assessed problem

- | | | |
|---|---|---|
| ☐ Hx of previous psych. illness | ☐ Mood-depression/mania/liability | ☐ Anxiety/agitation |
| ☐ Memory loss-short term/long term | ☐ Poor judgment | ☐ Behavior problems |
| ☐ Disorientation time/place/person | ☐ Hallucinations/delusions | ☐ Learning disabilities |
| ☐ Communication barriers | ☐ Emotional response to illness and care, body image | ☐ Growth and development |
| ☐ Interpersonal relationships | ☐ Socialization | ☐ Ethnicity |

Comments: _____

Review of System/Physical Assessment: No ☐ problems (leave blank)
S-subjective problem O-objectively assessed problem DNA- for did not assess

- | | | |
|--|---|---|
| Head
☐ Dizziness
☐ Headache | Eyes
☐ Vision loss (chose one)
☐ Minimal
☐ Moderate
☐ Severe
☐ Blind
☐ Not Determined
☐ Glasses
☐ Bluffed/double vision
☐ Change in vision (1 year)
☐ Glaucoma
☐ Cataracts
☐ PERRL | Ears
☐ Hearing loss (circle one)
☐ Minimal
☐ Moderate
☐ Severe
☐ Deaf
☐ Hearing aid
☐ Tinnitus |
| Mouth
☐ Gum problems
☐ chewing problems
☐ Dentures upper – lower - both | Nose
☐ Epistaxis | Neck and Throat
☐ Hoarseness
☐ Difficulty Swallowing |

Comments: _____

Cardiovascular

- | | | |
|---------------------------------------|--|---|
| ☐ Palpitations | ☐ Dyspnea on exertion | ☐ BR problems |
| ☐ Varicosities | ☐ Claudication | ☐ Paroxysmal nocturnal dyspnea |
| ☐ Chest pain | ☐ Fatigues easily | ☐ Orthopnea; # pillows _____ |
| ☐ Murmurs | ☐ Edema | ☐ Cyanosis |
| ☐ Pacemaker | | |
- ☐ WNL ☐ DNA

Comments: _____

Respiratory

- | | | | |
|--|-----------------------------------|--|---------------------------------|
| ☐ Shortness of breath | ☐ Wheezing | ☐ Sputum | ☐ Oxygen |
| ☐ Shape and symmetry | ☐ Cough | ☐ Breath sounds | ☐ Other |
- ☐ WNL ☐ DNA

Comments: _____

Carelink Health Care Services, LLC

Discharge Assessment

Gastrointestinal Track

☐
☐
☐

Indigestion
Nausea, vomiting
Ulcers

☐
☐
☐

Pain
Hernias
Diarrhea/constipation

☐
☐
☐

Rectal bleeding
Hemorrhoids
Gallbladder problems

☐
☐
☐

Jaundice
Tenderness
Ostomy

☐ WNL

☐ DNA

Comments: _____

Nutritional Status

☐
☐

Weight loss or gain last 3 months (amount _____)
Change in appetite

Height _____

Fluid intake amt/frequency _____

Weight (actual) _____ (reported) _____

Diet _____ meals prepared by _____ times per day/wk

Comments: _____

Genitourinary Tract

☐
☐
☐
☐

Frequency
Pain
Hematuria
Incontinence

☐
☐
☐
☐

Nocturia
Urgency
Vaginal discharge/bleeding
Hx hysterectomy

☐
☐
☐

Dysmenorrhea
Lesions
Prostate disorder

☐
☐
☐

Gravida/Para
Date last PAP test
Contraception

☐ WNL

☐ DNA

Comments: _____

Breasts (for both male and female)

☐

Lumps

☐

Tenderness

☐

Discharge

☐

Pain

☐

Does Self-breast exam

☐ WNL

☐ DNA

Comments: _____

Integumentary

☐
☐
☐
☐

Hair Changes
Pruritus
Color
Turgor

Skin Condition (Record code # on body area.
Indicate size to right of numbered category.)

1 Lesions

2 Bruises

3 Masses

4 Incisions

5 Scars

6 Ulcers

7 Decubiti

8 Pressure areas

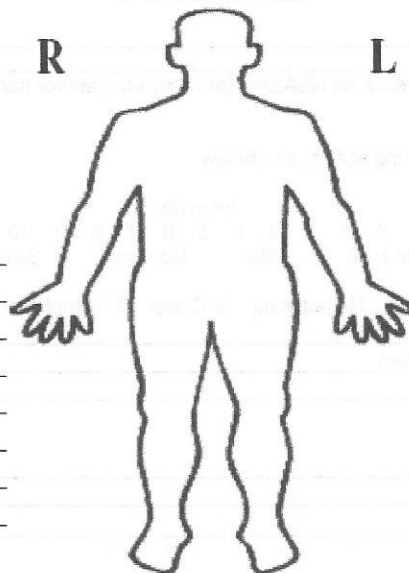
☐ WNL

☐ DNA

Comments: _____

Anterior

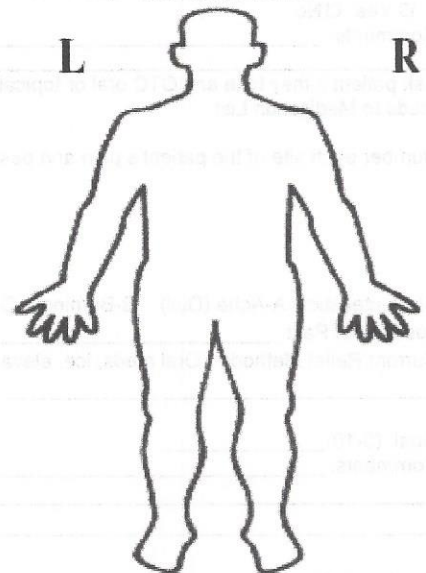
R



L

Posterior

L



R

Carelink Health Care Services, LLC

Discharge Assessment

Musculoskeletal, Neurological

- | | | | |
|---|--|---------------------------------------|--|
| ☐ Stiffness | ☐ Leg cramps | ☐ Seizure | ☐ Paralysis |
| ☐ Swollen joints | ☐ Numbness | ☐ Tenderness | ☐ Amputation |
| ☐ Coordination | ☐ Unequal grasp | ☐ Deformities | ☐ Tremor |
| ☐ Joint pain | ☐ Gait | ☐ Temp changes | ☐ Aphasia/inarticulate speech |
| ☐ Weakness | ☐ Syncope | ☐ Balance | ☐ Comatose |

☐ WNL ☐ DNA

Comments: _____

Endocrine and Hematopoietic

- | | | |
|-------------------------------------|---|---|
| ☐ Polyuria | ☐ Excessive bleeding or bruising | ☐ Intolerance to heat and cold |
| ☐ Polydipsia | ☐ Skin texture | ☐ Excessive perspiration |

☐ WNL ☐ DNA

Comments: _____

Pain Status

Frequency of Pain interfering with patient's activity or movement:

- | | |
|---|--|
| ☐ Patient has no pain or pain does not interfere with activity or movement | ☐ Daily, but not constantly |
| ☐ Less often than daily | ☐ All of the time |

Comments: _____

Non-Verbal Patient Pain Assessment: (Mark all observed or reported behaviors that may be pain related)

- | | | | |
|---|---------------------------------------|-----------------------------------|--------------------------------------|
| ☐ None Reported/Observed | ☐ Restlessness | ☐ Rigidity | ☐ Crying |
| ☐ Facial Grimaces | ☐ Guarding | ☐ Moaning | ☐ Other _____ |

Comments: _____

Does pain impact patient's daily functioning?

☐ Yes ☐ No

Comments: _____

Ask patient if they take any OTC oral or topical meds (such as NSAID's, Ben-Gay etc.) and/or herbal remedies to obtain pain relief. Add all OTC/Herbal meds to Medication List.

Number each site of the patient's pain and describe using scales, etc. below.

0	1	2	3	4	5	6	7	8	9	10
No Pain			Mild			Moderate				Severe

Characteristics: A-Ache (Dull) B-Burning C-Crushing R-Radiating S-Sharp T-Throbbing O-Other (describe) _____

Location of Pain: _____

Current Relief Methods (Oral meds, ice, elevation, other) _____

Goal: (0-10) _____

Comments: _____

Patient Signature _____ Date: _____

Nurse Signature _____ Title: _____ Date: _____

Discharge Summary

Date of Discharge: _____ Date Discharge Notice Provided: _____

Discharge Summary:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Nurse Signature: _____ Date: _____

