Hospital Discharge Plan Template

Patient Information			
Patient Name:		**Discharge Date:**	
Age/DOB:		**Discharge Destination:**	
Sex/Preferred Pronouns:		**Mode of Transport:**	
MRN #:		**Primary Care Provider:**	
Language Preference:		**Mobility Status:**	
Mental Status	☐ Alert and Oriented ☐ Altered Mental Status *(explain below)*	**Diet:**	☐ Full ☐ Soft ☐ Liquid ☐ Clear ☐ NPO ☐ Specialty: _____

Presenting Problem, Diagnosis, and Treatment	
Admission Diagnosis:	
Attending Provider(s):	Service: _____ Provider: _____ Service: _____ Provider: _____ Service: _____ Provider: _____

Presenting Problem, Diagnosis, and Treatment	
	Service: _____ Provider: _____
Past Medical History:	Neurologic: _____ Ear/Nose/Throat: _____ Cardiac: _____ Rheumatologic: _____ Pulmonary: _____ Dermatologic: _____ Abdominal: _____ Vascular: _____ Other: _____ _____ Surgical Hx: _____ _____
Treatment/ Procedure Details:	
Inpatient Complications:	☐ N/A ☐ Yes *(explain below)*

Recommendations for Continuity of Care	
Post-Acute Care Treatment/Services:	*(Example: wound care instructions)*
Medical Equipment Requirements:	*(Example: portable oxygen)* ☐ N/A ☐ Yes Equipment Type: _____ Company Name: _____ Contact Number: _____ ☐ Delivery? ☐ Pickup? ☐ Date/Time: _____ ☐ Location: _____ Equipment Type: _____ Company Name: _____ Contact Number: _____ ☐ Delivery? ☐ Pickup? ☐ Date/Time: _____ ☐ Location: _____
Mobility Assistance	☐ N/A ☐ Gait Belt ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Lift ☐ Type: _____ ☐ Other: _____

Recommendations for Continuity of Care	
Follow-Up Treatments/Therapies:	Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up?
Post-Discharge Specialty Providers:	Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up? Service: _____ Provider: _____ Phone #: _____ ☐ Call to Schedule Follow Up?

Recommendations for Continuity of Care	
PCP Follow-Up Appointment Scheduled? ☐ Yes ☐ Pending	**Date: _____** **Time: _____** **Provider: _____** **Phone #: _____** **Location: _____**

Discharge Medication List (and Considerations)	
Changes to Medication List?	☐ N/A ☐ Yes Changes: _____ _____ _____
Discharge Medication List	Drug Name: _____ Dose: _____ Route: _____ Schedule: _____ Indication: _____ Symptoms to watch for: _____ _____ _____ ☐ Stop Date? _____ Drug Name: _____ Dose: _____ Route: _____ Schedule: _____ Indication: _____ Symptoms to watch for: _____ _____ _____

Discharge Medication List (and Considerations)	
	☐ Stop Date? _____ Drug Name: _____ Dose: _____ Route: _____ Schedule: _____ Indication: _____ Symptoms to watch for: _____ _____ _____ ☐ Stop Date? _____ Drug Name: _____ Dose: _____ Route: _____ Schedule: _____ Indication: _____ Symptoms to watch for: _____ _____ _____ ☐ Stop Date? _____ Drug Name: _____ Dose: _____ Route: _____ Schedule: _____ Indication: _____ Symptoms to watch for: _____ _____ _____ ☐ Stop Date? _____
Discharge Medication Reconciliation Complete?	☐ Yes ☐ No
Discharge Medication Teaching Complete?	☐ Yes ☐ No

Discharge Planner Name: _____

Discharging Provider: _____

Discharge Education Provider: _____ Date/Time _____

Discharge Nurse: _____ Date/Time _____