## RED Discharge Preparation Workbook

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Room # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | Language preference | Interpreter/TranslationNeeded (Y/N) |
| Spoken communication |  |  |
| Written materials |  |  |
| Phone communication |  |  |

Fill out Contact Sheet for patient, proxy, and caregiver contact information.

MEDICAL TEAM \_\_\_\_\_\_

Attending:

Pager #

Pager #

Pager #

Case Manager:

Pager #

Language Services:

Pager #

Family worker:

Pager #

Pages to Team:

|  |  |  |
| --- | --- | --- |
| Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  |
| Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  |
| Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  |
| Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  | Pager: \_\_\_\_\_ Time: \_\_\_\_\_ C/B?: Y N  |

**DE Time:** (Record time spent on patient’s case)

|  |  |  |
| --- | --- | --- |
| Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ |
| Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ |
| Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ DE: \_\_\_\_ Total: \_\_\_\_\_\_ |

Floor Nurse: (Name of patient’s nurse)

|  |  |  |
| --- | --- | --- |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |

Contacts with family/caregiver

|  |  |  |
| --- | --- | --- |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |
| Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  | Date: \_\_\_\_\_\_\_ Nurse: \_\_\_\_\_\_\_\_\_\_  |

|  |  |  |
| --- | --- | --- |
| **Date** | **Outstanding Patient Teaching/Information**  | **Date Addressed** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Diagnoses

**Admitting Dx**:

**Comorbidities**:

**Discharge Dxs**

**2. Followup Appointments**

**PCP Appointment**

\_\_\_\_ **Patient has PCP?** If NO, Preferences (gender, location)?

**Patient requests for PCP appt** (weekdays, time of day)**:**

|  |  |
| --- | --- |
| **PCP Name** | **Day / Date / Time** |
|  |  |
| **Clinician to see at appt****(if not PCP)**  | **Location**  |
|  | **Address/Floor:****Phone #:****Fax #:**  |

**Does patient have transportation to PCP appt?**

\_\_\_\_ Yes \_\_\_ No \_\_\_\_ Transportation options discussed:

**Team appt. requests**:

**Additional Appointments, Tests, or Lab Work to be done POSTDISCHARGE**

**\*\*\*\*Attach Additional Appointment Sheet if Needed\*\*\*\***

|  |  |  |
| --- | --- | --- |
| **Day / Date / Time** | **Phone and Fax #** | **Reason / Test / Lab**  |
|  | **Ph:****Fax**: |  |
| **Provider** | **Location (Address, floor)** |
|  |  |
| **How patient will get to appointment** |
|  |

|  |  |  |
| --- | --- | --- |
| **Day / Date / Time** | **Phone and Fax #** | **Reason / Test / Lab**  |
|  | **Ph:****Fax**: |  |
| **Provider** | **Location (Address, floor)** |
|  |  |
| **How patient will get to appointment** |
|  |

|  |  |  |
| --- | --- | --- |
| **Day / Date / Time** | **Phone and Fax #** | **Reason / Test / Lab**  |
|  | **Ph:****Fax**: |  |
| **Provider** | **Location (Address, floor)** |
|  |  |
| **How patient will get to appointment** |
|  |

|  |  |  |
| --- | --- | --- |
| **Day / Date / Time** | **Phone and Fax #** | **Reason / Test / Lab**  |
|  | **Ph:****Fax**: |  |
| **Provider** | **Location (Address, floor)** |
|  |  |
| **How patient will get to appointment** |
|  |

|  |  |  |
| --- | --- | --- |
| **Day / Date / Time** | **Phone and Fax #** | **Reason / Test / Lab**  |
|  | **Ph:****Fax**: |  |
| **Provider** | **Location (Address, floor)** |
|  |  |
| **How patient will get to appointment** |
|  |

**3. Medicine**

**Allergies** \_\_\_\_ **No known allergies \_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Allergy** | **Patient Confirm (Y/N)** | **If No, Explain** | **Allergy** | **Patient Confirm (Y/N)** | **If No, Explain** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**4. Pharmacy**

**Uses hospital pharmacy?** **No \_\_\_\_ Yes \_\_\_\_**

|  |  |
| --- | --- |
| **Community Pharmacy Name** | **Phone #, Street Address, City** |
|   |   |

**Pt. plan to pick up meds upon d/c: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pt. requests pill box? No \_\_\_\_ Yes \_\_\_\_ (Pill box given \_\_\_\_)**

**5. Diet**

|  |  |
| --- | --- |
| **Discharge diet** |  |

Pt. needs diet info. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Substance use**

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance** | **SCM** | **Patient Report** | **Current Tx. or Interested in Cessation Info?** |
| **Alcohol** |  |  |  |
| **Tobacco** |  |  |  |
|   |  |  |  |

**7. Durable medical equipment needed at home?:** **No \_\_\_\_ Yes \_\_\_\_**

If pt. checks blood sugar with glucometer, how many times daily? \_\_\_\_\_\_\_

**New** **durable medical equipment ordered:** **Yes \_\_\_\_ No \_\_\_\_**

Type

Company name: Contact:

Address: Phone:

Delivery date:

Type

Company name: Contact:

Address: Phone:

Delivery date:

**8. Current or New Outpatient Services (ex. VNA, PT)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service

Company name: Contact:

Address: Phone:

Date scheduled:

Service

Company name: Contact:

Address: Phone:

Date scheduled:

Service

Company name: Contact:

Address: Phone:

Date scheduled:

**9. Outstanding Tests/Labs**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tests /Labs Pending** | **Date Conducted** | **Results Expected** | **Who Will Follow Up on the Result** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Final teaching completed?** Yes \_\_\_\_ Done by:DE \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_

**Reviewed what to do about problems?** Yes \_\_\_\_ No \_\_\_\_

**Patient understanding confirmed?** Yes \_\_\_\_ No \_\_\_\_

**Medicines reconciled with patient and medical team prior to final teaching?** Yes \_\_\_\_ No \_\_\_\_

**National guidelines checked prior to final teaching?** Yes \_\_\_\_ Date: \_\_\_\_\_\_\_\_\_No \_\_\_\_

**AHCP given and reviewed by DE with patient?** Yes \_\_\_\_ Time spent: \_\_\_\_minutes DE\_\_\_\_

No \_\_\_\_ Date mailed: \_\_\_\_\_\_\_\_\_

**If mailed, was patient called by DE to review AHCP?** Yes \_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ DE \_\_\_\_ No \_\_\_\_

**Communication/Notes**