RED Discharge Preparation Workbook

Patient Name ___________________________ **MRN** _________________ **DOB** _______________

Room # _______________

Date of admission _______________

	Language preference	**Interpreter/Translation Needed (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		

<table>
<tr><th>Day / Date / Time</th><th>Phone and Fax #</th><th>Reason / Test / Lab</th></tr>
<tr><td></td><td>Ph:
Fax:</td><td></td></tr>
<tr><th>Provider</th><th colspan="2">Location (Address, floor)</th></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><th colspan="3">How patient will get to appointment</th></tr>
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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