

Discharge Summary

Facility Name:

Facility Address:

Today's Date:

Resident Name:

Resident Date of Birth:

Allergies: YES NO ALLERGY TYPES:

Discharge Address/Destination

Responsible Party/Legally Authorized Representative

Date of Admission

Date of Discharge

Condition on Discharge

Adequate supply of medications for discharge: YES NO Number of Days of Medication:

Medication list provided to the resident which included Date/Time each medication was last administered: YES NO

Diet:

Physical Mobility: Steady Gait Unsteady Gait Assistance of 1 Utilizes Assistive Device

Assist with Medication Administration: Yes/No

Durable Equipment Used:

Cane	Wheelchair	Adaptive Eating Utensils	Oxygen	Glucometer
Walker	Shower Chair	Specialized Mattress	BiPap/CPAP machine	Other

Referrals/Services:

Home Health Agency

Substance Use Disorder Services

Occupational Therapy

Speech and Language Therapy

Psychological Services

Physical Therapy

Other

Future Appointments

Appointment Date

Appointment Time

Specialist Name

Signature of Staff Member Completing the Plan

Date

Resident Signature

Date Submitted to the Resident