DISCHARGE SUMMARY/COMPREHENSIVE ASSESSMENT

COMPLETE THIS FORM FOR ANTICIPATED DISCHARGES (HOME, B&C, another SNF)

RECAPITULATION OF STAY: _____

_____

_____

_____

1. MEDICAL STATUS & HISTORY (include diagnoses): _____

_____

_____

Discharge Vital Signs: BP_____ P _____ R _____ T _____ HT _____ WT _____

Laboratory Results: _____ No abnormals [ ]

2. NUTRITIONAL STATUS: Diet_____ Average Intake _____ Eating Habits: _____

IBW _____ Special Needs/Preference _____ Other _____

3. SENSORY AND PHYSICAL IMPAIRMENTS:

BLADDER	BOWEL	VISION	SPEECH	HEARING	PHYSICAL
[ ]Continent	[ ]Continent	[ ]Glasses Y / N	[ ]Verbal	[ ]Hearing Aids	[ ]Amputation
[ ]Incontinent	[ ]Incontinent	[ ]Blind R / L	[ ]Nonverbal	[ ]R / L	Site: _____
[ ]Occasional Inc.	[ ]Occasional Inc.	[ ]Cataracts	[ ]Aphasic	[ ]Refuses or	[ ]Paralysis R / L
[ ]F / C	[ ]Colostomy	[ ]Refuses to	[ ]Garbled	does not wear	[ ]Weakness R / L
[ ]Other _____	[ ]Other _____	wear glasses		[ ]Partially Deaf	[ ]Contractures
		[ ]Other _____		[ ]Deaf	Location_____
					_____
					_____

4. DENTAL CONDITION

[ ]Natural teeth
[ ]Cavities/Missing Teeth
[ ]Upper Denture
[ ]Lower Denture
[ ]Mouth Sores
[ ]Other _____

5. COGNITION/PSYCHOSOCIAL STATUS

[ ]Alert
[ ]Oriented
[ ]Confused at times
[ ]Disoriented-person/place/time
[ ]Comatose/vegetative state
[ ]Cooperative [ ]Uncooperative

6. ACTIVITY POTENTIAL/PARTICIPATION

[ ]Religion
[ ]Reading
[ ]Arts/Craft
[ ]Television
[ ]No Activities
[ ]Other _____

7. REHAB/DISCHARGE POTENTIAL

[ ]Good
[ ]Fair
[ ]Poor
[ ]Motivated to Self Care
[ ]Follows Instructions
[ ]Other_____

8. FUNCTIONAL STATUS:

	Independent	Needs Assist	Dependent
Bathing			
Dressing			
Eating			
Personal Hygiene			
Transfers			
Bed Mobility			
Toilet Use			
Ambulation			
Communication (specify)			

9. DRUG THERAPY (See Post Discharge Plan of Care or Transfer Record):

[ ] Allergies:_____ [ ] NKA Adverse Reactions:_____

10. SKIN CONDITION: [ ] Clear [ ] Rash [ ]Skin Tears [ ] Bruises Easily [ ] Pressure Sore (specify)_____

_____

PROVIDED TO RESIDENT/RESPONSIBLE PARTY [ ] YES [ ] NO

Completed by:_____ **Date**_____

RESIDENT NAME:_____ **Hospital #:**_____