Medications: ☐ None ☐ Resume all Home Meds Home Meds: ☐ Returned ☐ N/A Interactions: ☐ Food / Drug Drug / Drug Instructions Given	Medication	Dose	Route	How Often	Next Dose Due	Inst. Given	Rx Given
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Nutrition:
☐ No Restrictions
☐ Instructions Given

☐ Special Diet ____________________
☐ Supplements/Other ____________________

Activities:
☐ No Restrictions
☐ Instructions Given

☐ Walking ____________________ ☐ Exercises ____________________
☐ Bathing ____________________ ☐ Driving ____________________
☐ Lifting ____________________ ☐ Other ____________________

Special Care:
☐ None Required
☐ Instructions Given

(Include Type, What to Do)
☐ Dressing(s) ____________________ ☐ Drain ____________________
☐ I.V. ____________________ ☐ Tube(s) ____________________
☐ Other ____________________

Supplies/Equip.:
☐ None Required
☐ Instructions Given

(Include Type & How to Obtain)
____________________ ____________________
____________________ ____________________

Referrals:
☐ None Required
☐ Resource List

☐ Home Health Agency ____________________ Phone ________
☐ Equipment Supplier ____________________ Phone ________
☐ Other ____________________ Phone ________

Follow-Up Care:
☐ None Required

Who ________ When ________ Phone ________
Who ________ When ________ Phone ________
Who ________ When ________ Phone ________

Comments:
☐ None

____
____

I acknowledge receipt of the above discharge instructions. I have received all of my belongings.		*Patient/Significant Other demonstrates/verbalizes understanding of discharge instructions.*	
Signature of Patient, Family or Significant Other	Date/Time	Nurse Signature/Title	Date/Time

Physician's Comments

Physician's Signature

It has been a pleasure to care for you. If you have any problems or questions contact your physician.

Phone:

PATIENT IDENTIFICATION

Patient Discharge Instructions

N5405 Rev. (12/31/2003)