Discharge - Medical [30400673]

Height_____________________
Weight_____________________  
Allergies___________________

If appropriate for patient condition, please consider the following order sets:
For homebound patients only if on Home Health or Home Infusion #605
For FHS Cardiac Rehabilitation patients #835

General - Prior to Discharge

Diet - Prior to Discharge

[] Diet General
Diet effective now, Starting today
Viscosity/Liquids: _______________________________
Texture: ______________________________________
Fluid Restriction / day: __________________________
Supplements: __________________________________
Additional Modifiers: ___________________________

[] Diet Liquid
Diet effective now, Starting today
Diet: (Clear / Full) ___________________ (Required)
Additional Modifiers: ___________________________
Viscosity/Liquids: _______________________________

[] Diet Cardiac
Diet effective now, Starting today
Select/Nonselect: ___________________ (Required)
Additional Modifiers: __________________________
Viscosity/Liquids: _______________________________
Texture: ______________________________________
Fluid Restriction / day: __________________________
Supplements: __________________________________
Calories: ________________________________ (Required)

[] Diet Diabetic
Diet effective now, Starting today
Select/Nonselect: ___________________ (Required)
Additional Modifiers: __________________________
Viscosity/Liquids: _______________________________
Texture: ______________________________________
Fluid Restriction / day: __________________________
Supplements: __________________________________
Calories: ________________________________ (Required)

[] Other

Nursing Interventions Prior to Discharge

[] Nursing communication
Routine, Until discontinued, Starting today
Comments: _____________________________________

[] Nursing communication
Routine, Until discontinued, Starting today
Comments: _____________________________________

[] Nursing communication
Routine, Until discontinued, Starting today
Comments: _____________________________________

[] Keep central line/PICC line
Routine, Until discontinued, Starting today
Comments: _____________________________________

[] Discontinue IV
Routine, Once, Starting today For 1 Occurrences, Prior to Discharge
Comments: _____________________________________
Central line removal  
Routine, Once, Starting today For 1 Occurrences, Deaccess port.  
Comments: 

Foley catheter - discontinue  
Routine, Once, Starting today For 1 Occurrences, Remove retention catheter.  
Comments: 

Leg bag during the day  
Routine, Until discontinued, Starting today, Change retention catheter to leg bag (if ambulatory).  
Comments: 

Remove drains / tubes  
Routine, Once, Starting today For 1 Occurrences  
Tube(s):  
Drain(s):  
Remove surgical/IR drains.  
Comments: 

Remove sutures  
Routine, Once, Starting today For 1 Occurrences, Remove sutures/staples.  
Comments: 

Heart Failure Core Measures - ACE/ ARB  
[ ] Reason for no ACEI at discharge  
Reason for no ACEI at Discharge? ____________________________  
(Required)  
[ ] Reason no/ARB at discharge  
Reason for no ARB at Discharge? ____________________________  
(Required)  
[ ] Other  

Education - Prior to Discharge  
[ ] Patient education (specify)  
Routine, Once, Starting today For 1 Occurrences, Educate patient and document on patient educational record.  
Comments: 

[ ] Patient education (specify)  
Routine, Once, Starting today For 1 Occurrences, Educate patient and document on patient educational record.  
Comments: 

[ ] Provide patient education materials  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Provide patient education materials  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Tobacco cessation education  
Routine, Once, Starting today For 1 Occurrences, Educate patient and document on patient educational record.  
Comments: 

[ ] Other  

Discharge Instructions - Prior to Discharge  
[ ] Discharge instructions  
Routine, Once, Starting today For 1 Occurrences, Patient may be discharge if discharge criteria met. If unstable call physician for additional orders.  
Comments: 

[ ] Physician to see patient prior to discharge  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Call Physician with time of discharge  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Discharge instructions  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Discharge instructions  
Routine, Once, Starting today For 1 Occurrences  
Comments: 

[ ] Nursing communication  
Routine, Until discontinued, Starting today  
Comments: 

Date/Time ___________________  
Provider Initial:______________
### Nursing communication
- Routine, Until discontinued, Starting today
- Comments:

### Other

#### General - AMB Orders - Post Discharge

**Diet - Discharge**

- [ ] Advance diet as tolerated
  - Routine, Hospital Performed, Post Discharge
  - Target Diet: ____________________

- [ ] Diet NPO
  - Routine, Clinic Performed, Post Discharge
  - NPO except: ____________________

- [ ] Diet General
  - Routine, Clinic Performed, Post Discharge
  - Viscosity/Liquids: ____________________
  - Texture: ____________________
  - Fluid Restriction / 24h: ____________________
  - Sodium Modifiers: 2-3 gram sodium
  - Supplements: ____________________
  - Additional Modifiers: ____________________

- [ ] Diet Cardiac
  - Routine, Clinic Performed, Post Discharge
  - Select/Nonselect: ____________________ (Required)
  - Additional Modifiers: ____________________
  - Viscosity/Liquids: ____________________
  - Texture: ____________________
  - Fluid Restriction / 24h: ____________________
  - Sodium Modifiers: 2-3 gram sodium
  - Supplements: ____________________

- [ ] Diet Diabetic
  - Routine, Clinic Performed, Post Discharge
  - Select/Nonselect: ____________________ (Required)
  - Additional Modifiers: ____________________
  - Viscosity/Liquids: ____________________
  - Texture: ____________________
  - Fluid Restriction / 24h: ____________________
  - Sodium Modifiers: 2-3 gram sodium
  - Supplements: ____________________
  - Calories: ____________________ (Required)

[ ] Other

#### Activities Post Discharge

- [ ] Discharge activity
  - Routine, Clinic Performed, Post Discharge
  - Comments: ____________________

- [ ] Discharge activity
  - Routine, Clinic Performed
  - Comments: ____________________

- [ ] Nursing communication
  - Routine, Clinic Performed
  - Date to return to work/school: ____________________ (Required)
  - Comments: ____________________

- [ ] Activity as tolerated
  - Routine, Clinic Performed
  - Comments: ____________________

- [ ] Bed rest
  - Routine, Clinic Performed, Post Discharge
  - Comments: ____________________

- [ ] Lifting restrictions
  - Routine, Clinic Performed
  - Weight restriction of ____________________ (Required) # of lbs.
  - Comments: ____________________

- [ ] Activity order
  - Routine, Clinic Performed
  - Comments: ____________________

---

Date/Time ____________________ Provider Initial: ____________________

Page 3 of 7

<table>
<thead>
<tr>
<th>Discharge - Medical</th>
<th>[30400673]</th>
<th>PATIENT INFORMATION</th>
</tr>
</thead>
</table>

** Franciscan Health System **

St. Joseph Medical Center
St. Francis Hospital - St. Clare Hospital
St. Elizabeth Hospital - St. Anthony Hospital
Highline Medical Center
Harrison Medical Center
Franciscan Medical Group
Harrison Healtharetners
Regional Hospital

** PROVIDER ORDERS **
### Weight bearing restrictions (specify)
- Routine, Clinic Performed

### Other restrictions (specify):
- Routine, Clinic Performed

### Nursing Interventions - Post Discharge

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep Central/PICC Line in Place</td>
<td>Routine, Clinic Performed</td>
<td></td>
</tr>
<tr>
<td>Deaccess port: Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keep retention catheter in place</td>
<td>Routine, Clinic Performed</td>
<td></td>
</tr>
<tr>
<td>Change to Leg Bag</td>
<td>Routine, Clinic Performed</td>
<td></td>
</tr>
<tr>
<td>Keep Surgical/IR drains in place</td>
<td>Routine, Clinic Performed</td>
<td></td>
</tr>
<tr>
<td>Keep sutures/staples in place</td>
<td>Routine, Clinic Performed</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Wound Care

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound care</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Ostomy care</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Change dressing</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Remove dressing</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Nursing communication</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Nursing communication</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DME Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Qty</th>
<th>Length of need (days)</th>
<th>Frequency of use</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME Walker</td>
<td>1</td>
<td>(Required)</td>
<td>(Required)</td>
<td></td>
</tr>
<tr>
<td>DME Wheelchair</td>
<td>1</td>
<td>(Required)</td>
<td>(Required)</td>
<td></td>
</tr>
<tr>
<td>DME Nebulizer</td>
<td>1</td>
<td>(Required)</td>
<td>(Required)</td>
<td></td>
</tr>
<tr>
<td>DME Home Oxygen</td>
<td>1</td>
<td>Type of Home Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Discharge Instructions/Follow-Up

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge instructions</td>
<td>Routine, Clinic Performed, Post Discharge</td>
<td></td>
</tr>
</tbody>
</table>

---

**Date/Time** ___________________  **Provider Initial:**______________
Discharge instructions
Routine, Clinic Performed, Post Discharge
Comments:

Follow up with provider
Routine, Clinic Performed, Post Discharge
Provider Name:
Comments:

Follow up with provider
Routine, Clinic Performed, Post Discharge
Provider Name:
Comments:

Follow up with provider
Routine, Clinic Performed, Post Discharge
Provider Name:
Comments:

Follow-up primary provider
Routine, Clinic Performed, Post Discharge
Comments:

Follow-up Labs
Routine, Clinic Performed, Post Discharge
Comments:

Follow-up Diagnostic / Imaging Tests
Routine, Clinic Performed, Post Discharge
Comments:

Follow-up Tests
Routine, Clinic Performed, Post Discharge
Comments:

Other

Ancillary Referrals – Discharge

Physical Therapy
Internal Referral
Specialty Services
Referral Type:
Evaluate & Treat to:
How often should patient get therapy? __________
Number of Visits? __________
Comments:

Occupational Therapy
Internal Referral
Referral Type:
Comments:

Speech Therapy
Internal Referral
Referral Type:
Comments:

Diabetes Education with PCP
Internal Referral
Reason for Education: ________________________ (Required)
Diagnosis and Treatment: _______________________ (Required)
Injectable Medication Start: ______________________
Medication Type and Dose: ______________________
Adjust and Follow: _____________________________
Pump: ____________________________
Type of Pump: ____________________________
CGM: ____________________________
Referral Type: ____________________________
Comments:

Wound Care
Internal Referral
Reason for Referral: ________________________ (Required)
Expires: ________________________ (Required)
Interval: ________________________ (Required)
Count: ________________________ (Required)

Home Health
Internal Referral
Disciplines and Orders Service _______________________
Specialty Programs: _______________________

Date/Time ___________________  Provider Initial: ___________________
<table>
<thead>
<tr>
<th>Provider Orders</th>
<th>PATIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coumadin Clinic</td>
<td>Internal Referral</td>
</tr>
<tr>
<td>Reason:</td>
<td>(Required)</td>
</tr>
<tr>
<td>Is Cardioversion or Ablation Pending?</td>
<td>(Required)</td>
</tr>
<tr>
<td>What is the Goal INR?</td>
<td>(Required)</td>
</tr>
<tr>
<td>Duration of Therapy?</td>
<td>(Required)</td>
</tr>
<tr>
<td>Is patient on low molecular weight Heparin?</td>
<td>(Required)</td>
</tr>
<tr>
<td>Is patient on low molecular weight Heparin? [Yes – Lovenox, Yes – Fragmin, other (Add Comment), No]</td>
<td></td>
</tr>
<tr>
<td>What is the Heparin dose?</td>
<td></td>
</tr>
<tr>
<td>How Many In Range INRs Before Fragmin or Lovenox is Discontinued?</td>
<td></td>
</tr>
<tr>
<td>Responsible Group:</td>
<td>(Required)</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Internal Referral</td>
</tr>
<tr>
<td>Provider specialty:</td>
<td>(Required)</td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Number of Visits:</td>
<td>(Required)</td>
</tr>
<tr>
<td>Frequency of Cardiac Rehab sessions:</td>
<td>(Required)</td>
</tr>
<tr>
<td>Therapy Plan complete?</td>
<td></td>
</tr>
<tr>
<td>Heart Failure Clinic</td>
<td>Internal Referral</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Franciscan Transition Clinic</td>
<td>Internal Referral</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Home Infusion</td>
<td>Internal Referral</td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Education**

<table>
<thead>
<tr>
<th>Tobacco cessation education</th>
<th>Routine, Clinic Performed, Post Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC Results:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Nursing communication</td>
<td>Routine, Clinic Performed, Post Discharge</td>
</tr>
<tr>
<td>CC Results:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Patient action plan/sick plan:</td>
<td>Routine, Clinic Performed, Post Discharge</td>
</tr>
<tr>
<td>For post discharge problems, contact:</td>
<td></td>
</tr>
<tr>
<td>CC Results:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Disease specific instructions</td>
<td>Routine, Clinic Performed</td>
</tr>
<tr>
<td>Disease specific written instructions:</td>
<td></td>
</tr>
<tr>
<td>CC Results:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>IV line care instructions</td>
<td>Routine, Clinic Performed, Post Discharge</td>
</tr>
<tr>
<td>Instructions:</td>
<td></td>
</tr>
<tr>
<td>(Required)</td>
<td></td>
</tr>
<tr>
<td>Catheter care instructions</td>
<td>Routine, Clinic Performed, Post Discharge</td>
</tr>
<tr>
<td>Instructions:</td>
<td></td>
</tr>
<tr>
<td>(Required)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Discharge - Medical [30400673]**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Heart Failure - Patient Education</strong></td>
</tr>
<tr>
<td></td>
<td><strong>[ ] Patient education (specify)</strong></td>
</tr>
<tr>
<td></td>
<td>Routine, Clinic Performed</td>
</tr>
<tr>
<td></td>
<td>Weight monitoring and smoking cessation information per &quot;Working Together for Safe and Effective Care.&quot;</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td><strong>[ ] Patient education (specify)</strong></td>
</tr>
<tr>
<td></td>
<td>Routine, Clinic Performed</td>
</tr>
<tr>
<td></td>
<td>For weight gain greater than 3 pounds in 1 day or 5 pounds in 1 week, notify provider.</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td><strong>[ ] Other</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date/Time: ____________________________________________  Printed Name of Ordering Provider: ____________________________________________

Provider Signature: ____________________________________________  Date/Time: ___________________  RN Acknowledged: ___________________