Rhode Island HEALTH
Continuity of Care Form

Specific Discharging Agency:

ADMISSION DATE: _____ **DISCHARGE DATE:** _____

Patient Name: _____

Home Address: _____

_____

Being Discharged to: _____

Address: _____

_____ Phone: _____

Referral to: _____

Phone: _____

Contact Person @ Discharging Facility: _____

Phone/Beeper #: _____

The following information MUST be attached for Discharge to a Nursing or other facility:

☐ Patient demographic/registration sheet

☐ Medications and IV sheets ☐ Most recent lab results

Principal Diagnosis Of This Admission:	Surgery This Admission: Date:	Other Active Medical Problems:
Allergies, list and describe reactions:	Active Infection(s) this admission and site:	

Physician treatments/orders - Please specify number and frequency:

Diet: _____

Condition at Discharge: ☐ Improved ☐ Unchanged

☐ Skilled Home Nursing Care ☐ Respiratory Therapy

☐ Physical Therapy

☐ Occupational Therapy ☐ Speech Therapy

Additional physician comments:

List **ALL** medication(s) to be taken **POST** discharge:

New prescriptions ☐ were, or ☐ were not provided.

NOTE: Nursing homes require prescriptions for Schedule II medications.

Instructions Until Next Doctor Visit	Allowed	Supervised	Not Allowed	Instructions Until Next Doctor Visit	Allowed	Supervised	Not Allowed
Drive car or ride a bike				Weight bearing			
Ambulation				Stair climbing			
Shower/tub bath				Participation in gym class			
Housework				Contact/non-contact sports			
Lifting (weight limit lbs.)				Return to work/school/class			
Contact with others				Resume sexual activity		N/A	

Attending Physician's Signature:

_____ Date: _____

Discharge Summary dictated by: _____

(Please Print)

Physician(s) who will follow this patient after discharge (please print)

Name: _____ Phone: _____

Physician notified: ☐ Yes ☐ No

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH
Continuity of Care Form

Specific Discharging Agency:

Patient Name:

Does the patient have an Advanced Directive?

☐ No ☐ **Yes** ☐ Full ☐ DNR ☐ CMO

Immunization(s) this admission:

☐ INFLUENZA ☐ PNEUMOVAX

Tuberculin Status – if known:

☐ Negative ☐ Positive ☐ Unknown

DISCHARGED TO:

☐ Home – No Services
☐ Home care/services
☐ REHAB
☐ Nursing Home
☐ Other:_____

REFERRAL →

Active Infections

	Positive Culture	Active Infection	Date Resolved	Prior
MRSA				☐
VRE				☐
C.Diff.				☐

Agency:_____ Phone:_____

Visit(s) scheduled for:_____

_____

Information given to patient on discharge:

☐ Written information given on medications ☐ Food/drug interaction information ☐ Drug/drug interaction information
☐ Pain management instructions ☐ Therapeutic diet instructions ☐ Smoking cessation brochure
☐ Brochure CHF ☐ Comfort-One Band ☐ _____

Call physician if following occurs:_____

_____

_____

Wound Instructions:_____

_____

_____

Follow-up appointments with phone numbers:

MEDICATIONS: Nurse writes in the actual times prescriptions are to be taken and circle the next time the drug is due.

MEDICATION Pre-admission	MEDICATION New	DOSE	FREQUENCY	TIME LAST GIVEN	TIME NEXT DOSE	CONTINUE AFTER DISCHARGE Yes	CONTINUE AFTER DISCHARGE No
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Date completed:_____

Comment:

This information was reviewed and new prescriptions ☐ were, or ☐ were not provided. I understand these instructions and accept responsibility to carry them out and bring this form to my next doctor/clinic appointment.

Patient signature:_____

Or if discharged to parent/guardian – name(s)/signature:

_____

_____

Nurse's signature

Phone:_____

Interpreter(s) name:_____

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH **Continuity of Care Form: Physical & Functional Status – Nurse Form**

Patient Name:_____ Date:_____

Activities of Daily Living on discharge Day

CODES:
0 = Independent
1 = Supervision
2 = Limited Assistance
3 = Extensive Assistance
4 = Total Dependence
5 = Activity did not occur

_____ Transfer
_____ Dressing
_____ Toileting
_____ Personal hygiene
_____ Walking
_____ Eating
_____ Bathing

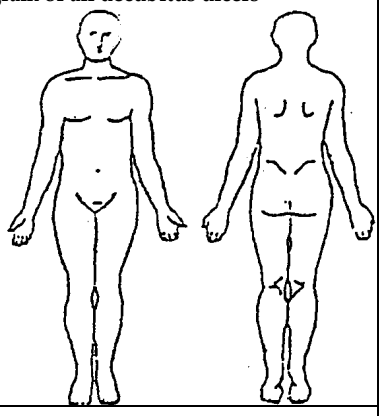
Mobility	Normal	Impaired
Upper extremities		
Lower extremities		

☐ Amputee _____
☐ Prosthesis use
☐ Equipment needed on discharge:_____

Stage and location on diagram of all decubitus ulcers

Stage 1 – area of persistent redness
Stage 2 – partial loss skin layers
Stage 3 – deep craters in skin
Stage 4 – breaks in skin, exposed muscle/bone

Other wounds present?
☐ No ☐ Yes – Describe:



Bowel and Bladder Assessment

Bowel/Bladder Program *(specify)*:

(Choose one for each)	Bladder	Bowel
Continent		
Occasionally incontinent		
Frequently incontinent		
Incontinent		

Date of last BM:_____
Ostomy (*type/size*):_____
Foley type:_____, balloon size:_____
Date foley changed:_____
☐ Dialysis (*type*):_____

Vital Signs

Height: _____ Weight: _____
Pulse range: _____ Resp. range: _____
Temp: _____ Blood Pressure: _____
On Oxygen @ _____LPM Pulse Oximeter range: _____

Pain Score 0 | 1 | | 5 | | 10
None Moderate Severe

Describe Pain:

Cognitive Status

Cognitive skills for daily decision making:
How well does the patient make decisions about organizing the day?
(Choose one response)
_____ Independent
_____ Modified independence – some difficulty in new situation
_____ Moderately impaired – decisions poor, cues/supervision needed
_____ Severely impaired – never or rarely decides

Level of consciousness?
(Choose one response)
_____ Alert _____ Drowsy, but aroused with minor stimulation
_____ Requires repeated stimulation to respond
_____ Responds only with reflex motor or autonomic system
_____ Effects or totally unresponsive

Mini Mental Health Examination

Patient is oriented to: _____ person, _____ place, _____ year
_____ Thought or speech organization is coherent
_____ Maintains attention, not easily distracted
_____ Short term memory OK – recalls 3 items after 5 minutes
(i.e., book, tree, house)

Communication

Primary Language:_____
Able to: _____ Understand _____ Speak _____ Read _____ Write

Secondary Language:_____
Able to: _____ Understand _____ Speak _____ Read _____ Write

Aphasia:_____ Expressive _____ Receptive

Sign language use: ☐ Yes ☐ No

Impairments – Hearing/Visual

Auditory (with hearing appliance, if used):
☐ Hears adequately.
☐ Minimal difficulty.
☐ Intermittently impaired.
☐ Highly impaired.
☐ Has hearing device.
Type:

Vision (with glasses, if used):
☐ Sees adequately.
☐ Impaired – sees large print but not regular print.
☐ Moderately impaired – limited vision cannot see headlines.
☐ Severely impaired – no vision or only sees light, color shapes.
☐ Uses visual device.
Type:

COMMENTS (If necessary to describe any deviation not addressed in nursing discharge summary):

_____ _____ _____ _____
Nurse signature *Title* *Date* *Contact number*

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH

Continuity of Care Form: Specific Discipline Summary Notes

Patient Name:_____

Discipline: **Nursing Discharge Summary** IV Present: ☐ No ☐ **Yes - Complete next line**:

Date IV Started_____ Time_____ IV Solution_____ Meds in IV_____ Rate_____

_____ _____ _____

Signature *Contact #/Unit* *Date*

Discipline:_____ Additional information attached: ☐ Yes ☐ No

_____ _____ _____

Signature *Contact #/Unit* *Date*

Discipline:_____ Additional information attached: ☐ Yes ☐ No

_____ _____ _____

Signature *Contact #/Unit* *Date*

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH **Continuity of Care Form: Consultation/Referral Form**

Patient Name:_____ Date completed:_____

Attending Physician:_____ Phone:_____

Responsible party:_____ Phone:_____

Relationship:_____ Guardian: ☐ Yes ☐ No POA ☐ Yes ☐ No

Facility/Residence Address:_____

_____

Agency Contact Person:_____ Phone:_____

Medicaid #:_____ Medicare #:_____

Other Insurance:_____

Patient referred to:_____

Reason for visit/consult/transfer

☐ Annual Exam ☐ Follow-up ☐ Acute:_____
(Specify)

☐ Consult/referral ordered by:_____

Does the patient have an Advanced Directive?

☐ No ☐ **Yes** ☐ Full DNR ☐ Partial DNR

Tuberculin Status – if known:

☐ Negative ☐ Positive ☐ Unknown

Active Infections

	Positive Culture	Active Infection	Date Resolved	Prior History
MRSA				☐
VRE				☐
C.Diff.				☐

Information attached: ☐ Demographic/Face Sheet ☐ Advanced Directive ☐ Diagnosis/Problem List ☐ Medication Sheet ☐ Recent X-ray or Lab

DESCRIPTION OF PROBLEM:

Expectation for situation - ☐ Long-term problem ☐ Short-term problem

CONSULTATION NOTES (continue on attachment as needed):

Recommendations/orders for the medical necessity of continuance of professional care as specified

Documents attached: ☐ Additional Notes & Diagnosis ☐ New Test Results ☐ New Prescription(s)/Orders

☐ Skilled Nursing Care
☐ Respiratory Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech Therapy

Follow-up visit required ☐ Yes ☐ No

Appointment date/time:_____

_____ PRINT attending physician's name

_____ *Phone*

_____ *Date*

ORIGINAL to – Agency/Patient | COPY to – Physician(s)/Agency | COPY - Chart