



DISCHARGE INSTRUCTIONS

FOR: _____

ROOM: _____

TRANSPORT WILL BE PROVIDED BY: _____

On _____

1. Patient will receive _____ via _____ prior to discharge.
Equipment to be delivered to _____
Phone: _____
2. Patient will receive _____. The services will begin within 24-48 hours post discharge.
Phone: _____
3. Please transfer required medications to _____ prior to discharge.
Phone: _____
4. Patient must follow up with their primary care provider 7-10 days post discharge.

SCHEDULED FOLLOW UP APPOINTMENTS

Appointment With	Date/Time	Phone



THERAPEUTIC DIET

☐ NAS ☐ NCS ☐ Renal ☐ Low sodium ☐ No Restrictions

DIET CONSISTENCY

☐ Regular ☐ Mechanical Soft ☐ Puree

LIQUID CONSISTENCY

☐ Thin ☐ Nectar ☐ Honey ☐ Pudding

ACTIVITY

- ☐ No restrictions, activity as tolerated
- ☐ Follow the restrictions or limitations below:

Weight bearing limitations: _____

Precautions: _____

COUMADIN THERAPY

Your next PT/INR is due on:

And will be drawn by:

Please send results to the dosing physician.

LABS

Lab Type	Frequency	Next Due

WOUND CARE



SKIN PREVENTIONS

ADDITIONAL INSTRUCTIONS



These discharge instructions have been reviewed with me in a language I understand, and my questions have been answered to my satisfaction.

I have received a copy of these discharge instructions.

Patient Signature

Date

Nurse Signature

Date

Please contact your discharge planner
if you have any questions or concerns.

at

If you experience any of the following

- Temperature over 101F
- Redness or drainage at a surgical incision
- Difficulty breathing
- Swelling of the feet or toes or redness of the calf
- Discoloration or the loss of movement or sensation of the operative leg
- Persistent or abnormal bleeding
- Persistent nausea or vomiting
- Any other changes in your health

Call your physician or for an emergency, dial 911