

McLaren Print System Order

Order No: 8841
 Order Date: 2015-02-07
 User: anna parsian
 Phone: 810-342-2375

Ship Location: Shannon Smith & Anna Parsian
 401 South Ballenger Hwy - 4 South
 Flint , MI 48532

Forms

Quantity: 500
 Paragon Dept No: 91570
 Dept Name: Case Management 4-South
 Company Number: 60

Order Total Price: 59.75

Item Number: 17598-B
 Item Description: Discharge by Transfer (with III. Nursing)
 Revision Date: 6/2014
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: 5 Hole Top
 Misc Info:

MCLAREN FLINT
 FLINT, MICHIGAN

DISCHARGE BY TRANSFER

III. NURSING (Complete & Sign)

Assessment	Intervention	Outcome	Notes
Activity	None		
Personal Hygiene	Bath & Personal Care Lower Extremities Mouth Care Oral Hygiene Hair Care Grooming		
Transfer	Transfer Bed Wheelchair Stair		
Level of Care	Home Home Home		
Living			

SELF CARE STATUS
 (Check and initial. Write 0 in space if none apply. Leave only 0 in space if applicable.)

Category	Item	0	1	2	3	4
CHECK IF PRESENT	DEBARBERS <input type="checkbox"/> Deposition <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor <input type="checkbox"/> Convulsion <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure <input type="checkbox"/> Fracture <input type="checkbox"/> Burns <input type="checkbox"/> Other					
	SOB <input type="checkbox"/> SOB with _____ location _____ <input type="checkbox"/> SOB at rest _____ location _____ <input type="checkbox"/> SOB on exertion _____ location _____ <input type="checkbox"/> SOB on exertion _____ location _____ SOB history changed _____					
	Behavior <input type="checkbox"/> Confused <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Incontinent <input type="checkbox"/> Other					
	Communication Ability (See III) Can speak English <input type="checkbox"/> Yes <input type="checkbox"/> No First/Other language spoken _____					
Patient Care <input type="checkbox"/> Self-care <input type="checkbox"/> Medication <input type="checkbox"/> Nutrition <input type="checkbox"/> Hydration <input type="checkbox"/> Other						

VITAL SIGNS: S/P _____ T _____ R _____ B _____

Sleep problems Yes No
 Confused in bed Yes No No No No

Family/caregiver assistance Yes No No No

Summary _____

Nurses Signature _____ RN Date ____/____/____ Time _____ Report called to receiving facility? Yes No

IV. SOCIAL WORK (Complete if applicable)
 Advanced Directives? Yes No Code Status _____
 Advance Plan Discussed with: SO Patient Family
 Referral made to: _____
 Summary _____

Signature and title _____

DISCHARGE BY TRANSFER
 0800

0800