

McLaren Print System Order

Order No: 9696
 Order Date: 2015-03-10
 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)

Activity	Assessment	Intervention	Response
Self Care Status			
Activity			
Personal Hygiene			
Dressing			
Transfer			
Local Motion			
Eating			

SELF CARE STATUS
 (Check and initial. Write 0 in space if unable to perform)
 (Mark only. Draw the score if applicable)

Activity	0	1	2	3	4
Activity					
Personal Hygiene					
Dressing					
Transfer					
Local Motion					
Eating					

CHECK IF PRESENT

Disabilities	Secondary	Behavior
<input type="checkbox"/> Impaired	<input type="checkbox"/> Swallow	<input type="checkbox"/> Irritability
<input type="checkbox"/> Vision	<input type="checkbox"/> Bowel	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hearing	<input type="checkbox"/> Bladder	<input type="checkbox"/> Depression
<input type="checkbox"/> Speech	<input type="checkbox"/> Skin	<input type="checkbox"/> Suicide
<input type="checkbox"/> Mobility	<input type="checkbox"/> Pain	<input type="checkbox"/> Other
<input type="checkbox"/> Cognition	<input type="checkbox"/> Other	

SKIN
 Clear skin _____ location _____
 Abrasions _____ location _____
 Wounds/Drains _____
 Other (specify) _____

Communication Ability Yes/No
 Can speak English Yes No
 If No, state language spoken _____

Patient Orientation
 Person Location Date
 Situation Other

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

Other problems? Yes No
 Confused in bed? Yes No
 Family/caregiver available? Yes 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: MD Patient Family
 Referral made to: _____
 Summary _____

Signature and title _____

DISCHARGE BY TRANSFER
 0800