McLAREN FLINT
FLINT, MICHIGAN

DISCHARGE BY TRANSFER

III. NURSING (Complete & SIgn)

	Independent	Needs Assistance	Unable to Do	SELF CARE STATUS (Check level of ability. Write S in space if needs supervision only. Draw line across if inapplicable.)
Bed Activity				Turns
				Sits
Personal Hygiene				Face
				Trunk & Perineum
				Lower Extremities
				Bladder Program
				Bowel Program
Dressing				Upper Extremities
				Trunk
				Lower Extremities
				Appliance, Splint
Transfer				Sitting
				Standing
				Tub
				Toilet
Loco-motion				Wheelchair
				Walking
				Stairs
Eating				

CHECK IF PRESENT

DISABILITIES
- ❑ Amputation
- ❑ Paralysis
- ❑ Contracture
- ❑ Decub. Ulcer

Incontinence
- ❑ Bladder
- ❑ Bowel
- ❑ Catheter
  Size: _____
  Date Inserted: _____

SKIN
- ❑ Ulcer size: _____ location: _____
- ❑ wound size: _____ location: _____
- ❑ Sutures/Staples

Date dressing changed: _____

Plan: _____

Behavior
- ❑ Quiet ❑ Withdrawn
- ❑ Noisy ❑ Friendly
- ❑ Belligerent ❑ Suspicious
- ❑ Cooperative ❑ Pleasant

Communication Ability Yes No
Can speak English ❑ ❑
If no, state language spoken:
_____

Patient Uses
❑ Appliance ❑ Colostomy ❑ Cane
❑ Crutches ❑ Prosthesis ❑ Walker
❑ Chair

VITAL SIGNS: B.P. P. R. Temp.

Sleep problems ❑ Yes ❑ No

Confused in AM ❑ Yes ❑ No PM ❑ Yes ❑ No

Family can help with care: ❑ Yes _____ ❑ No
(Name)

Summary:

❑ **Prescription for controlled substance required ❑ Yes ❑ No**
If yes, Please place in Discharge Sleeve.

Nurse's Signature: _____ R.N. Date: _____ / _____ / _____ Time: _____ Report called to receiving facility? ❑ Yes ❑ No

IV. SOCIAL WORK (Complete & Sign)

Advanced Directives? ❑ Yes ❑ No Code Status _____

Hospice Plan: Discussed with: ❑ MD ❑ Patient ❑ Family

Referral made to: _____

Summary:

Signature and title: _____

PT.

MR.#/RM.

DR.