Company Name

FORMAL PATIENT NOTIFICATION OF DISCHARGE

Date: _____ Time: _____

Patient: _____ ID#: _____

Your discharge from our service is planned for (Date) _____

Reason for discharge _____

GENERAL DISCHARGE INSTRUCTIONS

- Continue to follow _____ diet instructions you received.
- Take only medications prescribed by your doctor. Follow your written medication schedule.
- Discard all outdated medications.
- Keep doctor's name and phone number and your address clearly printed next to your phone or on your refrigerator.
- Keep names and numbers of individuals to be contacted in case of emergency next to your phone or on your refrigerator.
- Call 911 in the event of an emergency.
- Remember to plan on routine medical check-ups. Next doctor's visit is _____

Instruction for continued care / needs:

- ☐ Contact your doctor for a follow-up appointment
- ☐ Contact your doctor for any signs of symptoms of a change in your condition
- ☐ **Continue as taught** (until your physician changes the plan or instructs otherwise):
  - ☐ Medications (see medicine schedule)
  - ☐ Diet: _____
  - ☐ Treatments
  - ☐ Exercises
  - ☐ Procedures
  - ☐ Activities permitted
- ☐ **Contact your equipment company for:**
  - ☐ Problems or questions about equipment
  - ☐ Pick up of equipment that is not needed
  - ☐ Additional supplies (ie: test strips, etc.)
- ☐ Referrals made by the Social Worker for your continuing needs are listed on the Social Services Information Checklist (telephone numbers provided are for follow-up questions).
- ☐ Needles, syringes and finger-stick sharps are to be placed directly into a no-clear, puncture resistant, plastic container with a screw-type lid. When the container is full, tape the lid securely and place the container in the center of your regular garbage for pick-up.

Other special instructions: _____

_____

_____

_____

_____

If we can be of service to you in the future, or should you need further explanation, please feel free to contact us at

_____.

I, _____

Signature of Patient

acknowledge and understand the above instructions and discontinuation of services.

_____ _____

Nurse/Therapist Signature Date

_____ _____

Patient Signature Date