Discharge Planning Tool

MDS 3.0 Section Q Documentation

(Complete for all admissions to the facility)

Resident: _____ Room #: _____

Admitted from:

- ☐ hospital
- ☐ home
- ☐ nursing facility
- ☐ other: _____

Admitted for:

- ☐ Long term care
- ☐ Respite
- ☐ Other:_____
- ☐ Rehabilitation

Does the Resident express desire to be discharged from the facility?

- ☐ Yes; Where:_____
  _____
  _____
- ☐ No

Perceived length of stay:

- ☐ More than 90 days
- ☐ Less than 90 days
- ☐ Cannot determine at this time

Staff Signature: _____

Date:_____

Begin the discharge planning process if indicated by resident:

- Implement the attached form to help guide through the process
- Initiate Discharge care plan to meet resident's needs

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Discharge Planning Tool

(Complete form for only those who are questing to be discharged)

Intent:

The intent of this tool is to assist the resident, family and Nursing Home team process the resident's needs during discharge discussion. As information is obtained or changes, update the form and initial and date the change.

Lists Residents Medical Conditions below that may require supportive services then during each review, update each condition accordingly.	Review Date							

Allergies: _____

_____

Advance Directives Information: □POA □HCPOA □Living Will □Five Wishes □POLST

Perspective discharge date: _____

Anticipated Discharge to:

- ☐ Home
  - ❑ Will live alone completely independent
  - ❑ Will live alone with occasional support/supervision
  - ❑ Will live with other with direct supervision
  - ❑ Will live with other completely independent
- ☐ Group Living Environment with supportive services
- ☐ Group Living Environment without supportive services
- ☐ Another LTC facility:

  Name:_____ Phone:_____
- ☐ Other:

  Name:_____ Phone:_____

Has the Local Contact Agency been contacted to assist with the discharge process?

❑ Yes ❑ No

Anticipated Outpatient Services:

- ☐ Out patient

  Name:_____Phone:_____

  Services needed:
  - ❑ PT
  - ❑ OT
  - ❑ ST
  - ❑ RN
  - ❑ Other:_____

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☐ Home Health agency:

Name:_____

Phone:_____

Services needed:

- ❑ PT
- ❑ OT
- ❑ ST
- ❑ RN
- ❑ Other:_____

☐ Hospice:

Name:_____

Phone:_____

Medications & Treatments:

Check all those support systems that the resident will have upon discharge:

❑ Guardian	❑ Daughter/son	❑ Sibling
❑ Friend	❑ Other family	❑ Neighbor
❑ Spouse	❑ Significant other	

Caregiver Information:

Name:_____

Address/Phone:_____

_____

Additional Caregivers:

Name:_____

Address/Phone:_____

_____

Name:_____

Address/Phone:_____

_____

Availability of Caregiver(s)

_____

_____

_____

_____

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Transportation Needs:

- ❑ Ambulance/medicar
- ❑ Able to ambulate to/from car
- ❑ Automobile

Who will provide transportation or make arrangements for transportation?

_____

_____

Durable Medical Equipment:

- ❑ Wheelchair
- ❑ Cane
- ❑ Sock aid
- ❑ Safety rails
- ❑ Walker
- ❑ Reachers
- ❑ Ramp
- ❑ Elevated toilet seat
- ❑ Hospital bed
- ❑ Oxygen
- ❑ Other: _____

_____

Current activity/mental status:

- ❑ Independent
- ❑ Cooperative
- ❑ Full assist
- ❑ Minimal assist
- ❑ Agitated
- ❑ Oriented
- ❑ Alert
- ❑ Immobile
- ❑ Confused

Explain above as needed: _____

_____

_____

Financial planning:

- ❑ Medicaid
- ❑ Adult/protective services
- ❑ Disability application
- ❑ Secondary insurance
- ❑ Financially independent

Does resident have a leisure plan for post discharge?

- ❑ Yes
- ❑ No

What leisure time activities has the resident stated he/she will engage in post discharge? (list activity as well as plan to pursue the activity)

Activity:	Plan for pursuit:

Follow-up appointments:

_____

_____

_____

_____

_____

_____

_____

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Miscellaneous Information / Follow-ups: (use this section to plan out anything thing that needs follow-up prior to or post discharge either from the family, resident or facility)

Facility Contact Person:

Name: _____

Phone Number: _____

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