Delaware Health and Social Services
Division of Developmental Disabilities Services
Community Services

Discharge Worksheet

Name: ____________________________________ **Date:___________________**

Facility:___________________________________

Consultative Nurse/Staff/Shared Living Provider review the following with facility staff before leaving /discharge from the hospital.

	YES	NO	N/A
Did you receive written discharge instructions?			
Did you receive written prescriptions or have orders been sent to the pharmacy?			
Time of last medications: ____________			
Any recommended outpatient therapies? Physical _____ Occupational____ Speech________ Home Health Nurse____________ Hospice__________ **If yes, obtain prescription(s).**			
Any new treatments? (i.e., dressing changes, nebulizer, blood sugar checks, etc.)			
Any medication changes? (i.e., discontinued, increased/decreased dosage, new medication(s)			
Any change in previous diet?			
Any new physical restrictions?			
Any new adaptive equipment needed?			
Any new durable medical equipment?			
Do you have all necessary equipment/supplies to take home? If no, were needed supplies ordered? By whom____________________			
When can he/she return to day program/work? _____________________			
Healthcare Provider Follow up Appointment: Date: ______________ Time: ________			
Any testing ordered: Labs: Type_____________________________________ When: _______ Imaging: _______________________________________When: _______			
Physical Status if pertinent: Last BM: ___________ Last Urination: __________ Weight: __________ Blood Sugar: ________ Last Seizure: ____________ Skin Issues: ____			

Current Vital Signs				
Temp:	BP:	Pulse:	Respirations:	Pulse Ox:

Additional Comments:

Name of Consultative Nurse Contacted: ____

Date Contacted: _________________

____ ___________________

Signature of Staff Completing Worksheet Date

10/2023