

Chapter 4

Continuity of Care Planning

DISCHARGE PLANNING

By OMH Satellite Units in State Prisons

Discharge planning for parolees who have received mental health services in prison is done by OMH Satellite Unit Staff, parole, and local mental health service providers. .

By Central New York Psychiatric Center for CL §508 Patients

CNYPC Deputy Sheriff contacts county jail's transportation officer if possible 1 week in advance.

Sheriff's envelope to be sent with patient via transport officers, containing:

- Original and 1 copy of Transfer Sheet
- Copy of Sentence Papers (if available)
- County Jail Folder (if applicable)
- If HIV status included, Nursing Discharge Plan, Abnormal Lab work, Pharmacy Profile, are sent to jail physician only. (Physician will provide follow up at jail.)

Jail Physician envelope to be mailed 1 day before discharge, (if no physician address listed, envelope sent with transporting officer) containing:

- Transfer Sheet
- HIV Disclosure Cover Letter
- Nursing Discharge Plan
- Abnormal Lab work
- Pharmacy Profile

Mental Health envelope to be mailed one day before discharge, or if address same as jail, to be sent via transporting officers, containing:

- Transfer Sheet
- Discharge Summary
- Nursing Discharge Plan
- Core History/Evaluations
- Pharmacy Profile

- HIV Disclosure Cover Letter (if applicable). If 2 mental health contacts, envelope will be sent to each

Clinical Calls to be made at least one day before discharge to mental health contact and to include following information:

- Patient name and CNYPC Consecutive Number
- Admission and discharge dates
- Discharge medications
- Discharge diagnosis
- General dialogue regarding patient's condition
- Precautions

By Central New York Psychiatric Center for CL §402 Patients

CNYPC Discharge Coordinator to contact county jail's transporting officer, one week in advance.

Discharge paperwork

- Same as with 508 discharge

By Rochester Psychiatric Center, Regional Forensic Unit for All Patients

RPCRUFU staff discusses discharge date by phone with county jail staff. RFU staff discusses patient's response to treatment and continuing needs upon return to jail with local mental health department.

Discharge planning meeting is held, if possible.

Discharge paperwork

- Mailing to local mental health department containing:
 - Discharge Summary
 - Core History/Evaluation
 - Individual Service Plan
- Mailing to jail medical staff
 - Nursing Summary, including current medications, precautions, and response to treatment

Social Work staff contacts jail medical staff if there is a significant medical issue/management problem.

TRANSFER FROM COUNTY JAIL TO STATE DEPARTMENT OF CORRECTIONAL SERVICES

Mental health staff of county jail provides information to be transmitted with the inmate who is transferred to state prison:

- Assist corrections staff in completing the transfer information
 - Provide a discharge summary of mental health contacts with inmate
 - If necessary, make contact with DOCS reception center mental health staff via phone if the transfer is imminent and there is a need to share critical information, such as suicide risk, immediately. *(See page 4-3 for facility phone numbers)*
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CNYPC COMMUNITY SERVICES (Satellite Units)**Albion Satellite Unit**

Albion Correctional Facility
3595 State School Road
Albion, New York 14411
Phone: (716) 589-5511 Fax: (716) 589-5511
DOCS Facility: (same)

Arthurkill Mental Health Unit

Arthurkill Correctional Facility
2911 Arthurkill Road
Staten Island, New York 10309
Phone: (718) 984-2598 Fax: (718) 984-3683
DOCS Facility: (718) 356-7333

Attica Satellite Unit

Attica Correctional Facility
P.O. Box 149
Attica, New York 14011
Phone: (716) 591-2000 Fax: (716) 591-2000
DOCS Facility: (same)

Auburn Satellite Unit

Auburn Correctional Facility
Box 618
Auburn, New York 13024
Phone: (315) 253-9382 Fax: (315) 253-8401
DOCS Facility: (315) 253-8401

Bedford Hills Satellite Unit

Bedford Hills Correctional Facility
247 Harris Road
Bedford Hills, New York 10507
Phone: (914) 666-7280 Fax: (914) 241-3100
DOCS Facility: (914) 241-3100

Clinton Satellite Unit

Clinton Correctional Facility
P.O. Box 2000
Dannemora, New York 12929
Phone: (518) 492-2678 Fax: (518) 492-7650
DOCS Facility: (518) 492-2511

Collins Mental Health Unit

Collins Correctional Facility
PO Box 490
Collins, New York 14034
Phone: (716) 532-4588

Coxsackie Mental Health Unit

Coxsackie Correctional Facility
Box 200
Coxsackie, New York 12051
Phone: (518) 731-6778 Fax: (518) 731-6355
DOCS Facility: (518) 731-2781

Downstate Forensic Diag. Unit

Downstate Correctional Facility
Red Schoolhouse Road
Fishkill, New York 12524
Phone: (845) 831-5153 Fax: (845) 831-7137
DOCS Facility: (845) 831-6600

Eastern Mental Health Unit

Eastern Correctional Facility
Box 338
Napanoch, New York 12458
Phone: (845) 647-8577 Fax: (845) 647-2461
DOCS Facility: (845) 647-7400

Elmira Satellite Unit

Elmira Correctional Facility
Box 500
Elmira, New York 14902
Phone: (607) 733-2343 Fax: (607) 734-3901
DOCS Facility: (607) 734-3901

Fishkill Mental Health Unit

Fishkill Correctional Facility
Box 307
Beacon, New York 12508
Phone: (845) 831-4640 Fax: (845) 838-2956
DOCS Facility: (845) 831-4800

Five Point Satellite Unit

Five Point Correctional Facility
6600 State Route 96
Romulus, New York 14541
Phone: (607) 869-5111 Fax: (607) 869-5111

Great Meadow Satellite Unit

Great Meadow Correctional Facility
Box 51
Comstock, New York 12821
Phone: (518) 639-4117 Fax: (518) 639-4267
DOCS Facility: (518) 639-5516

Green Haven Satellite Unit

Green Haven Correctional Facility
Stormville, New York 12582
Phone: (845) 221-2963 Fax: (845) 227-8307
DOCS Facility: (845) 221-2711

Groveland Mental Health Unit

Groveland Correctional Facility
Rte. 36, Sonyea Road
Sonyea, New York 14556-0001
Phone: (716) 658-2871
DOCS Facility: (same)

Mid-State Mental Health Unit

Mid-State Correctional Facility
P.O. Box 216
Marcy, New York 13403
Phone: (315) 768-8581
DOCS Facility: (same)

Mohawk Mental Health Unit

Mohawk Correctional Facility
PO Box 8450
6100 School Road
Rome, New York 13440
Phone: (315) 339-5232 Fax: (315) 339-5232 ext. 6097
DOCS Facility: (315) 339-5232

Shawangunk Mental Health Unit

Shawangunk Correctional Facility
P.O. Box 750
Wallkill, New York 12589
Phone: (845) 895-9159 Fax: (845) 895-1404
DOCS Facility: (845) 895-2081

Sing Sing Satellite Unit

Sing Sing Correctional Facility
354 Hunter Street
Ossining, New York 10562
Phone: (914) 941-0108 ext. 1220
Fax: (914) 941-0108 ext. 1299
DOCS Facility: (same)

Sullivan Satellite Unit

Sullivan Correctional Facility
Box AG
Fallsburg, New York 12733
Phone: (845) 434-1488 Fax: (845) 434-0918
DOCS Facility: (845) 434-2080

Upstate Mental Health Unit

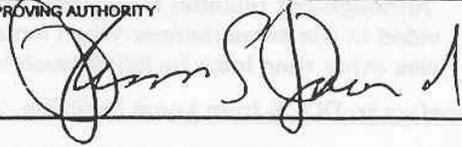
Box 2000
Malone, New York 12953
Phone: (518) 483-6997 ext. 1210
Fax: (518) 483-6997 ext. 6199
DOCS Facility: (518) 483-6997

Wende Satellite Unit

Wende Correctional Facility
P.O. Box 1187
Alden, New York 14004
Phone: (716) 937-3656 Fax: (716) 937-3731
DOCS Facility: (718) 937-4000

Woodbourne Mental Health Unit

Woodbourne Correctional Facility
Riverside Drive
Woodbourne, New York 12788
Phone: (914) 434-7730
DOCS Facility: (same)

 <p>STATE OF NEW YORK DEPARTMENT OF CORRECTIONAL SERVICES</p> <p>DIRECTIVE</p>	TITLE Inmate Information (Custodial and Health) During Transfer of Custody		No. 4019
	SUPERSEDES Dir. #4019 dtd. 04/15/94	DISTRIBUTION A	PAGE 1 OF 6 PAGES
REFERENCES (includes but are not limited to): Correction Law, Sec. 601(a)		APPROVING AUTHORITY 	

I. **PURPOSE.** To describe the procedure for the transmittal of detailed summaries of custodial and health information for the valid transfer of inmates between DOCS and local facilities. Section 601 (a) of Correction Law as amended by Chapter 227 Laws of 1981 requires this action.

II. **PROCEDURE**

A. Transfers from DOCS

- Each transferred inmate shall be accompanied by Custodial Transfer Information Form 3610, a Health Transfer Information Form 3611, and, if appropriate, a Patient Referral Form 3275 and photocopied health information (see Attachments A, B, and C).

A Patient Referral Form 3275 is to be completed whenever an inmate requires follow-up by a physician. Portions of the health record may be photocopied and forwarded to the receiving facility to ensure continuity of care.

The Health Transfer Information Form, Patient Referral Form, and any photocopied health information are to be enclosed in a sealed envelope marked with the following information for custodial staff:

From: (Sending Facility) To: (Receiving Facility) Inmate Name: _____ Inmate DIN _____ <input type="checkbox"/> Known Physical or Mental Health Problems _____ <input type="checkbox"/> Immediate Medical Attention Required _____ <input type="checkbox"/> Medication _____ CONFIDENTIAL-HEALTH INFORMATION ENCLOSED

- Where an inmate has been in the care of a Satellite Unit, the Mental Hygiene Unit Chief will prepare a summary of relevant psychological information which shall also be attached either in the Health envelope or in a separate envelope marked with the same information as the Health envelope.
- Each form shall provide information that is current as of the time of transfer.
- Each form shall be filled out by persons who are qualified to provide the information and have been designated by the Superintendent to do so.
- It is the responsibility of the Inmate Records Coordinator to ensure that the specified Custodial and Health Transfer Forms and, where required, the Mental Health envelope are attached to the other documents accompanying the inmate. Wherever any required forms have not been provided it shall be the responsibility of the Inmate Records Coordinator to report to his or her supervisor for appropriate action by the supervisor.
- A copy of the Custodial Transfer Form shall be retained in the Guidance Unit Folder of the inmate, and a copy of the Health Transfer Form shall be retained in the inmate's Active Health Record.

NO. 4019 Inmate Information (Custodial and Health) During Transfer of Custody

DATE 3/2/98 PAGE 2 OF 2

7. It is the responsibility of the facility that has requested a transfer order for the inmate in compliance with a court order to carry out the above procedures.
8. Although not required by Section 601 (a), custodial and health information should also be provided in the same manner when inmates are transferred to the custody of criminal justice agencies other than local facilities (such as other states or the federal prison system).

B. Transfers to DOCS from Local Facilities

1. Upon receipt of the Confidential Health Information it shall be sent immediately and unopened to the Health Unit.
2. Upon receipt of the Custodial Transfer Form it shall be sent immediately to staff receiving the inmate. The form shall be filed in the inmate's Guidance Unit Folder.
3. Action that is appropriate based on the information contained in the Custodial, Health, and Mental Health Forms shall be taken.

- C. Facility Procedures. Each facility shall establish written procedures to implement this directive, and the procedures shall be filed in the offices of the Superintendent of the facility.

Attachment A

FORM 3610 (4/98)

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONAL SERVICES

CUSTODIAL TRANSFER INFORMATION

PURSUANT TO SECTION 601A CORRECTION LAW

Sending Facility _____ Date: _____

Name (Last, first) _____ Din: _____

Alias (Last, first) _____ NYSID: _____

Date of Birth _____ Mo. Day Yr. In Custody Since _____ Mo. Day Yr.

Known Physical Problems? yes No

Known Mental Health Problems? yes No

Enter a "Y" or "N" for each item:

	Y	N		Y	N
Immediate medical attention required			Potential Victim		
Medication			Enemies (give names and locations (if known))		
Escape/Attempted escape/Hostage Taking			Good performance in work/prog. assignment		
Assaultive toward staff/inmates			Arson while in custody		
Drugs/Weapons/Other serious contraband			Restrictions on outside contacts		
Self-injury/Self-injury attempt			Other		
Central Monitoring Case					

Explain any item checked "Y" above to assist receiving staff to deal with inmate.

Adjustment in confinement: Good Fair Poor

Prepared by:

Name: _____ Signature _____

Title: _____ Telephone No. _____

Security Review:

Name: _____ Signature _____

Title: _____

Attachment A

(page 2)

INSTRUCTIONS FOR FILLING OUT CUSTODIAL TRANSFER FORM

1. Enter the inmate's name, alias, DIN, NYSID, and date of birth as given on Function 82 of the Reception/Classification System.
2. Relevant and up to date information concerning the inmate's behavior during custody should be included. If an item on the check list is checked "Y", specific substantiating information should be provided below.
3. "Known Physical Problems" and "Known Mental Health Problems" must be checked yes or no. Because medical information is in a sealed confidential envelope, it is crucial that any medical information relevant to custodial staff (such as physical limitations, epilepsy, medication) be included on the form. The information must be up to date.
4. Check "Central Monitoring Case" if the inmate is a State C.M.C. case or if the inmate is being transferred to New York City and his original New York City Inmate Transfer Information Sheet indicated he was a City C.M.C. case. Specify if the inmate is a State C.M.C. case, was a City C.M.C. case or both.
5. If an inmate is an overt homosexual, check "Other" and specify.
6. The general evaluation of the inmate's adjustment should be based on the following definitions:

Good:	The inmate's cooperation with the requirements of the facility is exceptional.
Poor:	The inmate has failed to cooperate with the requirements of the facility in a significant way.
Fair:	The inmate has performed acceptably. Fair is a broad category covering a wide range of inmates.
7. Information on the inmate's behavior prior to custody that is relevant and verified should also be included.

 <p>STATE OF NEW YORK DEPARTMENT OF CORRECTIONAL SERVICES</p> <h2 style="text-align: center;">REVISION NOTICE</h2>	<p>TITLE</p> <p style="text-align: right;">No. 4019</p> <p style="text-align: center;">Inmate Information (Custodial and Health) During Transfer of Custody</p>
	<p>NOTE: THIS REPLACES PAGES 5 & 6 DATED 12/01/99 Page 6 - Form 3275 (Attachment C) was revised 09/98</p>

ATTACHMENT B

HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTION LAW

This form is completed when the health record does not accompany the inmate and is necessary to provide continuity of care.

Health Care Staff (if available) place the form in a sealed envelope "Confidential - Health Information" indicating inmate name, sending facility and receiving facility.

The sending facility calls the receiving facility if inmate requires 24 hour nursing care and/or possible hospitalization to an acute center.

Attach *Suicide Prevention Screening Guideline Form* from intake, if available.

NAME _____ D.O.B. _____ DIN. _____ NYSID _____
Last First

HEALTH INFORMATION

A Physical Assessment has has not been completed.

	No	Yes	Date of Last Incidence		No	Yes	Date
Asthma or Breathing Disorder	_____	_____	_____	CXR	_____	_____	_____
Diabetes	_____	_____	_____	Tetanus	_____	_____	_____
Heart Disease	_____	_____	_____	Pap smear	_____	_____	_____
Hepatitis	_____	_____	_____	HIV Tested	_____	_____	_____
Seizure Disorder	_____	_____	_____	Result	_____	_____	_____
Syphilis	_____	_____	_____	PPD Date	_____	mm. Anergic	_____
Hypertension	_____	_____	_____	Treated	_____	_____	_____
IVDA	_____	_____	_____	VDRL Date	_____	Neg	Pos
Last Drug Used	_____	_____	_____	Treated	_____	_____	_____
Allergies	_____	_____	_____	G. C. Smear Date	_____	Neg	Pos
				Treated	_____	_____	_____

Dental Problems? No _____ Yes _____ Explain _____

List medications _____

MENTAL HEALTH INFORMATION

- Is the inmate currently receiving mental health services? Yes _____ No _____
If yes, problem: _____
Name of Tx Provider: _____ Telephone: () _____
- Is the inmate currently housed in a mental observation cell and/or under increased supervision for MH reasons? Yes _____ No _____ Reasons: _____
- Has the inmate been on suicide watch? Yes _____ No _____ Last Date: _____
Suicide attempt (s)? Yes _____ No _____ Last Date: _____
Has the inmate made suicidal statements/gestures: Yes _____ No _____ Last Date _____
- History of self mutilation? Yes _____ No _____ Explain: _____
- Past known psychiatric hospitalization? No _____ Yes _____ hospital and date: _____
- Current mental health related medications (dosage, date of last dose)? _____

Additional information related to current treatment should be noted, e.g., current medications, significant lab work, any information related to TB tx - such as sputum tests including pending reports with lab test numbers for followup. Any information regarding work disabilities, prostheses, hearing, blindness, previous hospitalization should also be noted. Use reverse side of form if needed.

Signature _____ Facility _____ Phone # (with extension) _____ Date _____

NO 4019 INMATE INFORMATION (CUSTODIAL AND HEALTH) DURING TRANSFER OF CUSTODY

DATE 12/18/00

THIS REPLACES PAGE 6 DATED 12/01/99

ATTACHMENT C

If this is a telemedicine encounter, has the inmate read the instructional sheet or been instructed on the telemedicine encounter? Yes [] No []

Date of Service: _____ Referred To: _____

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONAL SERVICES

PATIENT REFERRAL FORM

NAME _____ DIN _____ DOB _____ SS # _____

Vital Signs: Temp _____ Pulse _____ Resp _____ BP _____ Ht _____ Wt _____

I. Reason for Referral: (include present illness and symptoms, other specific diagnoses)

*Has inmate had any of these symptoms within the last week? [] Cough [] Fever [] Nightsweats [] Hemoptysis [] Severe Fatigue [] Weight Loss over 10lbs. in last 3 months (Explain above if symptoms noted)

II. Current Labs, X-Rays, or Diagnostic Tests related to Referral *(Include latest CD4 if applicable)

*CXR Date: _____ Result: _____

III. Current Medications and/or Treatments (Name, Route, Dose and Frequency with Start and Stop Dates)

Allergies No _____ Yes _____ Describe _____

IV. Significant Past Medical/Surgical History

	No	Yes	Date of Last Incidence	No	Yes	Date
Asthma or Breathing Disorder	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____	_____	_____

Other specific considerations (e.g., operations, disabilities):

Tetanus _____
HIV Tested _____
Result _____
Latest PPD Date _____ Neg [] Pos [] mm
Prior PPD Date _____ Neg [] Pos [] mm
Tritmnt. for: [] Posit PPD [] Diagnosed TB

Medications: _____

Start Date: _____ End Date: _____

List Drugs Used _____

V. Psychiatric Diagnosis? No _____ Yes _____ Specific Diagnosis _____

Psychiatric Medications _____

Referring Physician's Name _____ (Please Print)

Signature of Health Provider Completing Form _____ Date _____

Correctional Facility _____ Phone _____ Ext. _____

* Information required by SUNY Health Science Center for referral.

Distribution: Original - Hospital/consultant or Clinic Copy - Attach to consultation report/clinic info and place in Consultation Divider

CENTRAL NEW YORK PSYCHIATRIC CENTER
TRANSFER SHEET - COUNTY JAIL DISCHARGES

Date: _____

Patient Name: _____

“C” Number: _____

Transfer of one inmate will be made from this institution to _____

County Jail, and the following records will be sent to the Sheriff and Mental Health Contact (s)

as indicated:

TO SHERIFF:

_____ Sentence Papers

_____ Discharge Summary

_____ County Jail Record

TO MENTAL HEALTH UNIT:

_____ via mailing address

_____ via transport officers

_____ Discharge Summary - Core History/Evaluation
 Nursing Discharge Plan
 Pharmacy Profile/Lab Work

_____ Copies to Additional Mental Health Contact

TO JAIL PHYSICIAN:

_____ via mailing address

_____ via transport officers

_____ Nursing Discharge Plan

_____ Lab Work

_____ Pharmacy Profile

The above records and papers were prepared on _____

by _____
 (Name and Title)

The above inmate, records and papers were received on _____

by _____
 (Name and Title)

<p style="text-align: center;">DISCHARGE SUMMARY/SERVICE PLAN (INPATIENT)</p> <p>PART I - DISCHARGE SUMMARY PART II - NURSING DISCHARGE</p> <p>Destination: Date of Admission: Date of Discharge:</p>	<p>Patient's Name: "C"/Id. No.:</p> <p>Date of Birth:</p> <p>Unit/Ward No.:</p> <p>DIN No.:</p> <p>Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER</p>
<p>1. HISTORY: Attach existing documentation (or an abstract) which includes the following information, as indicated.</p> <ul style="list-style-type: none"> ▶ Presenting Problem(s) ▶ Mental/Physical Health ▶ Alcohol and Drug Use/Abuse ▶ Diagnosis ▶ Medications 	
<p>Attached: CORE HISTORY/EVALUATIONS NURSING DISCHARGE PLAN PHARMACY MEDICATION PROFILE</p> <p><u>REASON FOR ADMISSION:</u></p>	
<p>2. ALERTS: List risk factors including danger to self/others, CPL status, physical health conditions/needs, allergies (See Part II Nursing Discharge), etc.</p> <p><u>PRECAUTIONS:</u></p> <p><u>LEGAL ISSUES:</u></p> <p><u>SECURITY ISSUES:</u></p>	
<p>3. COURSE OF TREATMENT: Describe the course of treatment and the status of all goals which were to be met before discharge. Include the most effective treatments.</p> <p><u>COURSE OF TREATMENT:</u></p> <p><u>FAMILY INVOLVEMENT:</u></p> <p><u>SPECIAL TREATMENT PROCEDURES:</u></p>	

Patient's Name:
"C"/Id. No.:

Discharge Summary continued

4. RECOMMENDATIONS ON DISCHARGE:

THERAPY/COUNSELING:

EDUCATIONAL/VOCATIONAL:

MEDICATIONS:

5. DIAGNOSIS: Enter a "P" in front of the principal diagnosis.

Axis I:

Axis II:

Axis III:

Axis IV: Psychosocial Stressors:

a. Stressor(s):

b. Severity: 1. | | None 2. | | Mild 3. | | Moderate
 4. | | Severe 5. | | Extreme
 6. | | Catastrophic 0. | | Inadequate Info./No Change

c. Duration: 1. | | Predominately Acute Event
 2. | | Predominately Enduring Circumstances

Axis V: Global Assessment of Functioning: (Enter two digit scores from 01-90)

a. Current GAF Score _____ Past GAF (Highest) Score _____

6. CONDITION ON DISCHARGE: Describe current functioning.

DISCHARGE MENTAL STATUS:

Staff Signature:

Title:

Physician's Signature:

Title:

/
Dictated:
Transcribed:

CNY-161B (Rev 3/99) Part II: NURSING DISCHARGE SUMMARY Central New York Psychiatric Center	(PLEASE PRINT) Name: "C" No. Ward: DOB: DIN#:
--	---

1. **SPECIAL ALERTS/PRECAUTIONS** -- (include allergies, self-abuse, non-compliance, homicidal/suicidal ideation, potential/actual EPS, escape risk, sexual acting out, etc.). If none, state "None".

2. **CURRENT BEHAVIOR:**

3. **LAB WORK** -- List most recent ones; include dates and attach copies of results to Nursing Discharge Summary:

4. **CONSULTATIONS** -- List consultations which may require follow-up and attach copies of recommendations. If none, state "None":

5. **TESTS / IMMUNIZATIONS** while at CNYPC. (List any necessary follow-up under #6 - Physical Health.):

TEST	DATE	RESULTS	TEST	DATE	RESULTS
Mantoux			Pap Smear		
Diphtheria/Tetanus		N/A	Mammogram		
Pneumococcal Vaccine		N/A	Chest X-Ray		
Flu Vaccine		N/A	EKG		
Hepatitis B Vaccine		N/A	Other		
Physical Exam		N/A			

NURSING DISCHARGE SUMMARY

6. PHYSICAL HEALTH:

Activity Tolerance _____

Diet _____

Sleep Pattern _____

Weight _____

Personal Hygiene: Self-Care: Yes No

Needs Monitoring: Yes No

The following physical health problems and recommendations are noted. If none, state "None".

7. DISCHARGE MEDICATIONS -- (Include Dosage, Time, Route, Form. If applicable, date next injection due):

8. PATIENT EDUCATION/HEALTH TEACHING PROVIDED -- (Include medication, diet, HIV, general health, stressors, etc.):

9. SUMMARIZE PATIENT'S RESPONSE TO EDUCATION/HEALTH TEACHING, including need for reinforcement of education/health teaching.

10. OTHER NURSING CONSIDERATIONS -- If none, state "None".

11. I reviewed these discharge instructions and had an opportunity to ask questions.

PATIENT SIGNATURE

Date

Discharge R.N. Signature

Date

Receiving RN Signature

Date