DOB: EMRN:

ACCT #:

LOCATION:

* - - *

Georgia Health Sciences Health System
DISCHARGE ORDER / Instruction Summary

Admission Date: _____ Discharge Date: _____ Discharge Time: _____

Attending Physician: _____ MCG Referring MD: _____

Primary Care MD: _____ Primary Care MD Phone/Fax: _____

Record all diagnoses/conditions/comorbities impacting care.

Principal Diagnosis: 1. _____

Other Diagnoses:

2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Record* all *operations and procedures during this stay.

Principal Procedure: 1. _____

Other Procedures/Operations:

2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Discharge Medications and Dosages:

1. _____ Daily 2x day 3x day 4x day As Needed
2. _____ Daily 2x day 3x day 4x day As Needed
3. _____ Daily 2x day 3x day 4x day As Needed
4. _____ Daily 2x day 3x day 4x day As Needed
5. _____ Daily 2x day 3x day 4x day As Needed
6. _____ Daily 2x day 3x day 4x day As Needed
7. _____ Daily 2x day 3x day 4x day As Needed
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

INSTRUCTIONS TO PATIENT AT TIME OF DISCHARGE:

♥ Diet: _____

♥ ☐ Daily Weights (All Heart Failure Patients) If weight increases _____ over target weight of _____ then _____ until weight returns to target weight. If weight decreases _____ below target weight of _____ then _____

♥ Call Healthcare Provider or 911 if the following symptoms worsen: _____

♥ Physical Activity: _____

♥ Smoking Cessation: ☐ Patient Counseled ☐ Other _____

Special Instruction Sheets: ☐ Angioplasty/PCI ☐ Pacemaker/Defibrillator Placement ☐ Coumadin ☐ Heart Failure

Patient Teaching (Treatments/Needs): _____

♥ **Follow-up Care:** ☐ Clinic _____ Ph.# _____ ☐ Dr. _____ Date/Time: _____

☐ Clinic _____ Ph.# _____ ☐ Dr. _____ Date/Time: _____

☐ Referring Physician Office Care: _____

☐ Other Agency/Facility: _____

Physician's Signature: _____ Date: _____

Discharge Summary Dictated: ☐ No ☐ Yes Date: _____ MIN#: _____

Nurse Reviewer: _____ Date: _____

The above has been explained to me and I have had an opportunity to ask questions.

☐ Patient ☐ Parent ☐ Guardian's Signature: _____ Date: _____

THIS CERTIFIES THAT I HAVE BEEN RELEASED BY THE STAFF OF THE MCG HEALTH SYSTEM AND THAT I AM TAKING ALL OF MY PERSONAL BELONGINGS (VALUABLES AND CLOTHING) WITH ME.

DATE: _____ SIGNED: _____ WITNESS: _____

♥ Mandatory for heart failure patients

MC 484/8826 Rev. 2/8/12 MCG145

ORDDC