Rhode Island HEALTH
Continuity of Care Form

Specific Discharging Agency:

Patient Name:______________________

Home Address:______________________

____

Being Discharged to:______________________

Address:______________________

______________________ Phone:__________

Referral to:______________________

Phone:______________________

Contact Person @ Discharging Facility:______________________

Phone/Beeper #:______________________

The following information MUST be attached for Discharge to a Nursing or other facility:

☐ Patient demographic/registration sheet
☐ Medications and IV sheets ☐ Most recent lab results

Principal Diagnosis Of This Admission:	Surgery This Admission: Date:	Other Active Medical Problems:
Allergies, list and describe reactions:	Active Infection(s) this admission and site:	

Physician treatments/orders - Please specify number and frequency:

Diet:______________________

Condition at Discharge: ☐ Improved ☐ Unchanged

☐ Skilled Home Nursing Care ☐ Respiratory Therapy
☐ Physical Therapy
☐ Occupational Therapy ☐ Speech Therapy

Additional physician comments:

List **ALL** medication(s) to be taken **POST** discharge:

New prescriptions ☐ were, or ☐ were not provided.

NOTE: Nursing homes require prescriptions for Schedule II medications.

Instructions Until Next Doctor Visit	Allowed	Supervised	Not Allowed	Instructions Until Next Doctor Visit	Allowed	Supervised	Not Allowed
Drive car or ride a bike				Weight bearing			
Ambulation				Stair climbing			
Shower/tub bath				Participation in gym class			
Housework				Contact/non-contact sports			
Lifting (weight limit lbs.)				Return to work/school/class			
Contact with others				Resume sexual activity		N/A	

Attending Physician's Signature:

______________________Date:__________

Discharge Summary dictated by:______________________
(Please Print)

Physician(s) who will follow this patient after discharge (please print)

Name:______________________ Phone:__________

Physician notified: ☐ Yes ☐ No

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH
Continuity of Care Form

Specific Discharging Agency:

Patient Name:

Does the patient have an Advanced Directive?

☐ No ☐ **Yes** ☐ Full ☐ DNR ☐ CMO

Immunization(s) this admission:

☐ INFLUENZA ☐ PNEUMOVAX

Tuberculin Status – if known:

☐ Negative ☐ Positive ☐ Unknown

DISCHARGED TO:

☐ Home – No Services
☐ Home care/services
☐ REHAB
☐ Nursing Home
☐ Other:________

REFERRAL ➡

Active Infections

	Positive Culture	Active Infection	Date Resolved	Prior
MRSA				☐
VRE				☐
C.Diff.				☐

Agency:______________________________Phone:________

Visit(s) scheduled for:________________________________

____

Information given to patient on discharge:

☐ Written information given on medications
☐ Pain management instructions
☐ Brochure CHF
☐ Food/drug interaction information
☐ Therapeutic diet instructions
☐ Comfort-One Band
☐ Drug/drug interaction information
☐ Smoking cessation brochure
☐ ______________________________

Call physician if following occurs:____________________________________

____

____

Wound Instructions:____

____

____

Follow-up appointments with phone numbers:

MEDICATIONS: Nurse writes in the actual times prescriptions are to be taken and circle the next time the drug is due.

MEDICATION Pre-admission	New	DOSE	FREQUENCY	TIME LAST GIVEN	TIME NEXT DOSE	CONTINUE AFTER DISCHARGE Yes	No
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Date completed:____________________

Comment:

____

Nurse's signature

Phone:______________

This information was reviewed and new prescriptions ☐ were, or ☐ were not provided. I understand these instructions and accept responsibility to carry them out and bring this form to my next doctor/clinic appointment.

Patient signature:____

Or if discharged to parent/guardian – name(s)/signature:

____

Interpreter(s) name:____

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH — Continuity of Care Form: Physical & Functional Status – Nurse Form

Patient Name:_______________________________________ Date:________________

Activities of Daily Living on discharge Day

CODES:
0 = Independent
1 = Supervision
2 = Limited Assistance
3 = Extensive Assistance
4 = Total Dependence
5 = Activity did not occur

_____ Transfer
_____ Dressing
_____ Toileting
_____ Personal hygiene
_____ Walking
_____ Eating
_____ Bathing

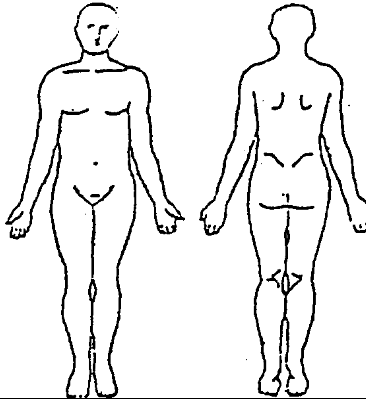
Mobility	Normal	Impaired
Upper extremities		
Lower extremities		

☐ Amputee ______________________________
☐ Prosthesis use
☐ Equipment needed on discharge:______________________
____

Stage and location on diagram of all decubitus ulcers

Stage 1 – area of persistent redness
Stage 2 – partial loss skin layers
Stage 3 – deep craters in skin
Stage 4 – breaks in skin, exposed muscle/bone

Other wounds present?
☐ No ☐ Yes – Describe:
____
____
____
____
____



Bowel and Bladder Assessment

Bowel/Bladder Program *(specify)*:
(Choose one for each)

	Bladder	Bowel
Continent		
Occasionally incontinent		
Frequently incontinent		
Incontinent		

Date of last BM:_____________________________________
Ostomy (*type/size*):_____________________________________
Foley type:__________________, balloon size:______________
Date foley changed:__________________________________
☐ Dialysis (*type*):_____________________________________

Vital Signs

Height: _______ Weight: _______
Pulse range: _______ Resp. range: _______
Temp: _______ Blood Pressure: _______
On Oxygen @ _______LPM Pulse Oximeter range: _______

Pain Score: 0 | 1 | | 5 | | 10
None — Moderate — Severe

Describe Pain:

Cognitive Status

Cognitive skills for daily decision making:

How well does the patient make decisions about organizing the day?
(Choose one response)

_______ Independent
_______ Modified independence – some difficulty in new situation
_______ Moderately impaired – decisions poor, cues/supervision needed
_______ Severely impaired – never or rarely decides

Level of consciousness?
(Choose one response)

_______ Alert _______ Drowsy, but aroused with minor stimulation
_______ Requires repeated stimulation to respond
_______ Responds only with reflex motor or autonomic system
_______ Effects or totally unresponsive

Mini Mental Health Examination

Patient is oriented to: ______ person, ______ place, ______ year
_______ Thought or speech organization is coherent
_______ Maintains attention, not easily distracted
_______ Short term memory OK – recalls 3 items after 5 minutes
(i.e., book, tree, house)

Communication

Primary Language:_____________________________________
Able to: _____ Understand _____ Speak _____ Read _____ Write

Secondary Language:___________________________________
Able to: _____ Understand _____ Speak _____ Read _____ Write

Aphasia:_____________ Expressive _______ Receptive

Sign language use: ☐ Yes ☐ No

Impairments – Hearing/Visual

Auditory (with hearing appliance, if used):
☐ Hears adequately.
☐ Minimal difficulty.
☐ Intermittently impaired.
☐ Highly impaired.

☐ Has hearing device.
Type:

Vision (with glasses, if used):
☐ Sees adequately.
☐ Impaired – sees large print but not regular print.
☐ Moderately impaired – limited vision cannot see headlines.
☐ Severely impaired – no vision or only sees light, color shapes.

☐ Uses visual device.
Type:

COMMENTS (If necessary to describe any deviation not addressed in nursing discharge summary):

____________________ ____________________ ____________________ ____________________
Nurse signature *Title* *Date* *Contact number*

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH

Continuity of Care Form: Specific Discipline Summary Notes

Patient Name:______________________________

Discipline:__________**Nursing Discharge Summary**__________ IV Present: ☐ No ☐ **Yes - Complete next line**:

Date IV Started____________________ Time________ IV Solution______________________ Meds in IV______________________Rate_________

_____________________________ _____________________________ _____________________________

Signature *Contact #/Unit* *Date*

Discipline:____________________________________ Additional information attached: ☐ Yes ☐ No

_____________________________ _____________________________ _____________________________

Signature *Contact #/Unit* *Date*

Discipline:____________________________________ Additional information attached: ☐ Yes ☐ No

_____________________________ _____________________________ _____________________________

Signature *Contact #/Unit* *Date*

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart

Rhode Island HEALTH **Continuity of Care Form: Consultation/Referral Form**

Patient Name:____________________ Date completed:__________

Attending Physician:____________________ Phone:________

Responsible party:____________________ Phone:________

Relationship:__________ Guardian: ☐ Yes ☐ No POA ☐ Yes ☐ No

Facility/Residence Address:____________________

Agency Contact Person:____________________ Phone:________

Medicaid #:__________ Medicare #:__________

Other Insurance:____________________

Patient referred to:____________________

Reason for visit/consult/transfer

☐ Annual Exam ☐ Follow-up ☐ Acute:____________ (Specify)

☐ Consult/referral ordered by:____________________

Does the patient have an Advanced Directive?

☐ No ☐ **Yes** ☐ Full Code ☐ DNR

Tuberculin Status – if known:

☐ Negative ☐ Positive ☐ Unknown

Active Infections

	Positive Culture	Active Infection	Date Resolved	Prior History
MRSA				☐
VRE				☐
C.Diff.				☐

Information attached: ☐ Demographic/Face Sheet ☐ Advanced Directive ☐ Diagnosis/Problem List ☐ Medication Sheet ☐ Recent X-ray or Lab

DESCRIPTION OF PROBLEM:

Expectation for situation - ☐ **Long-term problem** ☐ **Short-term problem**

CONSULTATION NOTES (continue on attachment as needed):

Recommendations/orders for the medical necessity of continuance of professional care as specified

Documents attached: ☐ Additional Notes & Diagnosis ☐ New Test Results ☐ New Prescription(s)/Orders

☐ Skilled Nursing Care
☐ Respiratory Therapy ☐ Physical Therapy
☐ Occupational Therapy ☐ Speech Therapy

Follow-up visit required ☐ Yes ☐ No

Appointment date/time:____________________

____________________ __________ __________
PRINT attending physician's name *Phone* *Date*

ORIGINAL to – Agency/Patient	COPY to – Physician(s)/Agency	COPY - Chart