

McLaren Print System Order

Order No: 30443
 Order Date: 2017-09-08
 User: Rochelle Wilson
 Phone: 810-342-2375

Ship Location: McLaren Flint -4 South Attn: Rochelle Wilson
 401 S. Blallenger Hwy
 Flint, MI 48532

Forms
 Quantity: 100
 Paragon Dept No: 91570
 Dept Name: Case Management
 Company Number: 60

Order Total Price: 74.40

Item Number: 17598-B
 Item Description: Discharge by Transfer (with III. Nursing)
 Revision Date: 12/2015
 Print: 1 sided full color
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info: ss; red and black

McLaren Flint
 Flint 48532

DISCHARGE BY TRANSFER

III. NURSING (Complete & Sign)

Self-Care Activity	Independent	Supervised	Assisted	Dependent	None
Bathing					
Dressing					
Transfer					
Locomotion					
Eating					

SELF CARE STATUS
 (Check level of ability. Write 0 in space if needs supervision only. Circle the scores if applicable.)

TRANSFERS	SKIN	BEHAVIOR
Type _____ Date _____ Location _____ Reason _____ Date changed _____ Plan _____	Wound _____ location _____ Subst/Suppl _____ Date changed _____ Date treated _____	<input type="checkbox"/> Control <input type="checkbox"/> Withdrawn <input type="checkbox"/> None <input type="checkbox"/> Friendly <input type="checkbox"/> Belligerent <input type="checkbox"/> Suspicious <input type="checkbox"/> Cooperative <input type="checkbox"/> Prejudiced Communication Ability Yes/No Can speak English <input type="checkbox"/> <input type="checkbox"/> If no, state language spoken _____

DISABILITIES

<input type="checkbox"/> Amputation	<input type="checkbox"/> Seizures
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Contracture	<input type="checkbox"/> Catheter
<input type="checkbox"/> Debrid. Ulcer	<input type="checkbox"/> Sore

VITAL SIGNS S/P/R/T/Temp _____

Sleep problems Yes No
 Confused in AM Yes No PM Yes No
 Family can help with care: Yes No (Name) _____

Summary: Prescription for controlled substance required Yes No
 If yes, Please place in Discharge Sleeve.

Nurse's Signature _____ RN Date _____ Time _____ Report called to receiving facility? Yes No

IV. SOCIAL WORK (Complete & Sign)

Advanced Directives? Yes No Code Status _____
 Hospice Plan: Discussed with: MD Patient Family
 Referral made to: _____
 Summary: _____

Signature and title _____

DISCHARGE BY TRANSFER
 (Book No. 014)