

McLaren Print System Order

Order No: 7384
Order Date: 2014-11-29
User: anna parsian
Phone: 810-342-2375

Ship Location: Debra Hoffman/Anna
 401 South Ballenger Hwy - 4 South
 Flint , MI 48532

Forms
Quantity: 500
Paragon Dept No: 91570
Dept Name: Case Management 4-South
Company Number: 60

Order Total Price: 59.75

Item Number: 17598-B
Item Description: Discharge by Transfer (with III. Nursing)
Revision Date: 6/2014
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info:

McLaren Flint
 Flint, Michigan

DISCHARGE BY TRANSFER

III. NURSING (Complete & Sign)

SELF CARE STATUS
(Check and initial with 0 in space if health expert
 assess only (See the notes if applicable))

Self-Care	Assessment	Signature	Date
Feeding			
Medication			
Mobility			
Personal Hygiene			
Transfer			
Wound Care			
Activity			

CHECK IF PRESENT

DEBAR/DIRIS	Secondary	Behavior
<input type="checkbox"/> Depression	<input type="checkbox"/> Suicide	<input type="checkbox"/> Hostile
<input type="checkbox"/> Paranoia	<input type="checkbox"/> Abuse	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Compulsions	<input type="checkbox"/> Self-harm	<input type="checkbox"/> Aggressive
<input type="checkbox"/> Delirium	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Inappropriate
<input type="checkbox"/> Delusions	<input type="checkbox"/> Disinhibition	<input type="checkbox"/> Poor judgment
<input type="checkbox"/> Sleep, diet	<input type="checkbox"/> Sex	<input type="checkbox"/> Poor self-care
	<input type="checkbox"/> Substance use	

SKIN

Skin intact

Wound site location

Wound site location

Wound dressing

Wound dressing changed

VITAL SIGNS: S/P _____ P _____ B _____ Temp _____

Deep tenderness No Yes No Yes No Yes No

Contract to test No Yes No Yes No Yes No

Pain No Yes No Yes No

Family/caregiver No Yes No Yes No

Communication Ability Yes No

Can speak English Yes No

Fluently speaks another language Yes No

Patient Uses

Telephone Calendar Cash

Medication Healthcare Mobility

Other _____

Summary _____

Nurses 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 NO Patient Family

Referral made to: _____

Summary _____

Signature and title _____

DISCHARGE BY TRANSFER
FORM 100-100-0000



0500