SOH002782-0001

PORTSMOUTH HEALTHCARE NHS TRUST

CLINICAL POLICY

APPENDIX 1

DISCHARGE PLAN/CHECKLIST

PATIENT NAME: ______________________________

HOSPITAL NUMBER: ______________________________

NAMED NURSE: ______________________________

SECTION A	TICK AS APPROPRIATE YES	NO	DATE/COMMENTS
1. Patient/Carer involvement	☐	☐	....
2. ADL Assessment required	☐	☐	....
3. If YES, referral to OT	☐	☐	....
4. Stirling Scale completed	☐	☐	....
5. Barthel score completed	☐	☐	....
6. Referral to social worker	☐	☐	....
7. Aftercare requirements	☐	☐	....
8. Referral to community nurse (DN, H/V, CPN)	☐	☐	....
9. Transport required	☐	☐	....
IF YES Arrangements made	☐	☐	....
10. Patient informed of discharge date and time	☐	☐	....
11. Carer/relatives informed of discharge date and time	☐	☐	....

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SUMMARY OF ARRANGEMENTS

SECTION B IMMEDIATELY BEFORE DISCHARGE

	TICK AS APPROPRIATE YES	NO	DATE/COMMENTS
12. Transfer form completed	☐	☐	....
13. District spell summary completed	☐	☐	....
14. Property/valuables returned?	☐	☐	....
15. Written information for patient	☐	☐	....
16. Contact name/telephone number	☐	☐	....
17. Medical certificate issued	☐	☐	....
18. 7 days supply of drugs TTO	☐	☐	....
19. Relatives/carers informed	☐	☐	....