DISCHARGE PASSPORT

HOSPITAL:		WARD:	
PATIENT NAME – Date of Birth - Female / Male ADDRESS – BOROUGH – Telephone Number -		GP NAME Address of Surgery - Contact Number: NHS NUMBER -	
NOK / Named Carer Address & Telephone Number:		Patient aware of the Referral - YES NO	Safeguarding Concerns – YES NO

REASON FOR ADMISSION (Including PMH, Diagnosis, Specialist recommendation, Fluid/Food Restrictions)			
Date of Admission		Estimated Date of Discharge	
Reason for Admission			
PMX			
PATHWAY	0. RESTART	1. NEW POC (Increase)	
	2. Not direct to home/ICB	3. 24 hour care	
POC REQUIRED			

PREVIOUS SUPPORT			
Times (per day)			
Task(s)			
Single/Double			
Provider	Local Authority	Direct Payments	Family

COMMUNICATION			
Language Spoken:	Interpreter Required:		
Hearing Problems	YES	NO	Please provide details:
Vision Problems	YES	NO	Please provide details:
Cognitive Impairment	YES	NO	Please state which assessment was used + score -
Behavioural/ Mental Health Needs/Substance Abuse	YES	NO	Please provide details:

Current Safeguarding process in place	YES	NO	Please provide details:

CURRENT FUNCTION - Completed by Nurse or OT

Task	Independent	Assistance of one	Assistance of two	Additional Information/ Rehabilitation Goals
Toileting				
Washing				
Dressing				
Feeding				
Meal Prep				

MOBILITY		EQUIPMENT	
Transfers – Bed Chair Toilet		Equipment at home	
Mobility & Stairs		Equipment ordered	
Weight Bearing		Expected delivery date	
Walking Aid			
Falls Risk	Low ☐	Medium ☐	High ☐
History of Falls	Yes ☐	No ☐	
Bed mobility	Independent ☐	Assistance ☐	

Completed by : **Date and Time:**

CONTINENCE

Continent of faeces	YES ☐	NO ☐	Continent of urine	YES ☐	NO ☐
Continence Aids	YES ☐	NO ☐	Comments		

NURSING

Allergies	YES ☐	NO ☐	Self -Medicating	YES ☐	NO ☐	Limos Input Required	YES ☐	NO ☐
Pain issues?	YES ☐	NO ☐	Drug Chart / Mar Chart	YES ☐	NO ☐	New Catheter	YES ☐	NO ☐
Dossett Box on admission?				YES ☐	NO ☐			

TISSUE VIABILITY

Pressure ulcer's	Location	Grade
Wound's -Dressing/Regime	Location	Grade
Pressure Care Equipment Required ?	Required – N/A	Delivery Date -

Pressure Care Monitoring Required ?	YES	NO
	☐	☐

NUTRITION			
Dietary Requirements	YES ☐	NO ☐	Details
Feeding Pump/Equipment used ?	YES ☐	NO ☐	Type
Completed by :	Date and Time:		

RECOMMENDED INTERIM SUPPORT agreed by MDT				
	AM	Lunch	Tea	PM
Task				
Times and Duration				
Single/Double Handed				
24 hour care (BEXLEY ONLY) ☐	Reason:			
Completed by :	Date and Time:			

DISCHARGE PLAN					
Lives Alone	YES ☐	NO ☐	Door Keys	YES ☐	NO ☐
Access	Own Keys ☐	Family/NOK/Carer ☐		Keysafe + Code ☐	
Risks Identified	Pets ☐	Clutter ☐	Infestation ☐	Other ☐	
Food	No Issues ☐	Needs Shopping ☐	UHL Food Package ☐	SS Food Parcel ☐	
Money for basics	YES ☐	NO ☐	Clothes	YES ☐	NO ☐
Pendant Alarm	YES ☐	NO ☐	Completed by: Date and Time:		

TRANSPORT BOOKING			DISCHARGE PAPERWORK		
Address Confirmed	YES ☐	NO ☐	DNR/Peace Plan	YES ☐	NO ☐
Booked	YES ☐	NO ☐	Discharge Summary	YES ☐	NO ☐
Mobility	Stretcher ☐	Chair ☐	District Nurse Ref	YES ☐	NO ☐
Oxygen	YES ☐	NO ☐	Comments		
Infection	YES ☐	NO ☐	TTOs	YES ☐	NO ☐
Stairs	YES ☐	NO ☐	Other		
REFERENCE Number					
Completed by:	Date and Time:				

IMPORTANT To Complete

PATIENT CONSENT

Has the patient consented to the Discharge Plan and agreed that the information detailed on this form can shared with NOK and other authorised Health and Social Care providers?

YES	**NO**
YES - With limitations	**Please detail:**
UNABLE TO CONSENT	
Consent from Person with Power of Attorney	
Deputyship	
Best Interest Assessor Decision Maker	

CONTACT DETAILS FOR POWER OF ATTORNEY FOR HEALTH AND WELFARE :

Signature – Patient/Decision Maker	**Date and Time:**

COMMENTS

Date and Time	Comments