DISCHARGE FOLLOW UP CONSENT

Affix Patient Information Label HERE

DISCHARGE FOLLOW UP CONTACT - CONSENT

BINDING MARGIN — DO NOT WRITE

Authority for Discharge Nurse to contact my Health Care Professionals

I hereby authorise the Discharge Nurse of (Organisation's name) to contact my Health Care Professional (GP, Psychiatrist, and/or Case Manager) to provide health information related to my discharge. No information will be disclosed unless it has been previously discussed with me. *Please note*, in life threatening situations we are obliged to provide necessary information to health care providers without your consent.

☐ General Practitioner Name: _____ Phone No.: _____

Fax No: _____

Address: _____

☐ Other Health Professionals (e.g. Psychiatrist, Nurse, Social Worker, Psychologist)

Name: _____ Phone No.:_____

Fax No: _____

Address: _____

☐ Authority for the Hospital Pharmacist to contact my regular community pharmacist.

Pharmacy Name: _____ Phone No.: _____

Address: _____

☐ I consent to the Discharge Nurse contacting me after I am discharged.

Home Phone: _____ Mobile Number: _____

Email: _____

Can the Discharge Nurse leave a discrete message ☐ Yes ☐ No

Patient Signature: _____ Date: _____/_____/_____

Witnessed by: _____ Date: _____/_____/_____

If you do not consent to any of the statements, cross out that statement.

This consent form is valid for a period of 12 months from the date of this form being signed.

PSYCHIATRIST'S DISCHARGE SUMMARY

**Note: A typed copy of the Psychiatrist's final discharge letter will be forwarded via regular mail.*

Affix patient information label here

Date of admission:_____/_____/_____ Date discharge: _____/_____/_____

Diagnosis (DSM-IV)

Axis 1: _____

Axis 2: _____

Axis 3: _____

_____

History - Presenting Problem(s) and Mental state

In Hospital Progress and Treatment

Medications ceased this admission

Summaries to: (tick box if faxed at discharge)

☐ _____

☐ _____

Signature: _____

Date: _____/_____/_____

PSYCHIATRIST'S - DISCHARGE SUMMARY

BINDING MARGIN — DO NOT WRITE

BINDING MARGIN — DO NOT WRITE

HOSPITAL DISCHARGE SUMMARY

Affix Patient Information Label HERE

Instructions - Medical Officer to complete pages 1 and 2 (Medications); Pharmacy page 2 (sign/date); Nursing staff to complete page 2 Community pharmacy and Webster pack details, and page 3 - complete all sections prior to faxing within 12hrs to 48hrs of patient discharge.

VMO:_____ Psychiatrist's Discharge Summary to follow (within 2 weeks)

Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

Reason for Admission: _____

Referral by (☑ relevant item) ☐ GP ☐ Psychiatrist ☐ Transfer from another hospital ☐Allied Health Clinician

☐Community Mental Health Team ☐ Self-presentation ☐ Other (specify) _____

Mode of Discharge: (☑ relevant item) ☐ Planned ☐ Unplanned discharge due to breach of contract

☐ Early Discharge VMO Approval ☐ Transfer to another hospital ☐ Self-discharged against medical advice

Diagnosis (Axis) (for this episode of care): 1. _____

2. _____

3. _____

New Physical findings and Test results **(Reports attached Tick box ☑ if relevant)**

_____

_____

_____

_____

Medical follow-up required (For example: Urgency of GP follow-up, repeat tests, Non-psych Specialist management required, etc.)

_____

_____

_____

Alerts **(☑ all relevant items)** ☐No Alerts ☐Suicide - history ☐Self-Harm ☐Substance abuse ☐Falls risk

☐Harm to Others ☐Cognitive impairment ☐Medical Allergy ☐Aggression ☐Other _____

Comment: _____

Next treatment phase (**☑ all relevant items**)

☐General Practitioner follow-up ☐Psychiatrist follow-up ☐ Day Program ☐Discharged at own risk

☐Community Mental Health Care follow-up ☐Webster medications pack ☐Other (specify) _____

☐Transfer to another hospital (reason) : _____

Medical Officer's Signature: _____ Designation VMO / Registrar / CMO
(circle relevant response)

Print Name: _____ Date: _____

HOSPITAL DISCHARGE SUMMARY — MEDICAL