

Needs	Date	Day			Date	Day			Date	Day			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
<input type="checkbox"/> Diet instructions for patients at Nutritional risk	5/10	S	OD	V	7/10	OD	V	9/10	OD	V			Garcia [Signature] [Signature]
<input type="checkbox"/> Diet advice for home													
Discharge Planning													Nurse / Doctor
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting concerns													
<input type="checkbox"/> Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													Nurse / Doctor
<input type="checkbox"/> Smoking cessation													
<input type="checkbox"/> Weight control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other risks													

LEARNER (L) - P - Patient, M - Mother, F - Father, S - Spouse other _____ (State Relationship)
 PROCESS (P) - OD - Oral Discussion, D - Demonstration, W - Written Material
 OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written material given and explained (if any):

Reports Given:

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	_____	_____	_____	Diet Advice	_____	_____	_____
ECG Report	_____	_____	_____	CT Scan Report	_____	_____	_____
Doppler Report	_____	_____	_____	CT Scan Film	_____	_____	_____
X-Ray Report	_____	_____	_____	ECHO Report	_____	_____	_____
X-Ray Film	_____	_____	_____	Ultrasound Report	_____	_____	_____
Compact Disc	_____	_____	_____	Any other report	_____	_____	_____

Name of Attendant / Patient _____ Signature _____
 Name of Discharge Nurse: _____ Emp ID: _____ Signature _____
 Name of Doctor _____ Emp ID: _____ Signature _____