

Needs	Date	Day ___			Date	Day ___			Date	Day ___			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician Goyal DS DS
<input type="checkbox"/> Diet instructions for patients at Nutritional risk	5/10	S	OD	V	7/10	OD	V	9/10	OD	V			
<input type="checkbox"/> Diet advice for home													Nurse / Doctor
Discharge Planning													
<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):

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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 _____