CORAM
CVS/specialty infusion services

DISCHARGE SUMMARY

Patient Name: _____ **ID#** _____ **Date of D/C:** _____

Caregiver Name: _____ **Caregiver Phone Number:** _____

Diagnoses (list all): _____

Therapies provided: ☐ Anti-infectives ☐ Parenteral Nutrition ☐ Biologics ☐ Immune Globulin ☐ Pain Management ☐ Chemotherapy ☐ Other: _____

Start of Care Date: _____ **Last dose given:** _____

Access Device remaining at time of D/C: ☐ None 1. _____ (Description) 2. _____ (Description)

Reason for discharge: Code (listed on back of form): _____ **Desc:** _____

Summary of Care Provided:

☐ Pharmacy Services ☐ Nutrition Services Nursing Services Provided by: ☐ Coram ☐ Agency ☐ No Nursing Care

☐ Nutrition assessment/consultation ☐ Access device care & maintenance ☐ Pharmaceutical monitoring

☐ Education to provide self-care and monitoring ☐ Nursing assessments ☐ Lab collection and/or result monitoring

☐ Equipment/supply management ☐ Wound care ☐ Therapy review/OBRA counseling

☐ Medication Administration

☐ Other, describe: _____

Response to Therapy:

Status of symptoms since initiation of therapy: ☐ Resolved ☐ Improved ☐ Unchanged ☐ Declined

Describe unmet Care Plan goals: _____

Ongoing Patient Care Needs:

☐ Patient/caregiver independent with care

☐ Patient/caregiver requires the following services after discharge from Coram:

- ☐ Wound Care Provided by: _____ Phone: _____
- ☐ PT/OT/ST (circle all that apply) Provided by: _____ Phone: _____
- ☐ Home Health Aide Provided by: _____ Phone: _____
- ☐ Other: _____

The following discharge instructions were provided to the patient and/or caregiver:

☐ Notify physician of fever greater than 100 degrees F within 24 hrs of discharge

☐ Notify physician if complications develop at access device site within 48 hours after device is removed

☐ Notify physician if symptoms return after medication has been discontinued

☐ Leave occlusive dressing in place for 24 hours

☐ Other: _____

Physician name: _____ **Phone:** _____

Fax: _____

Signature of clinician completing form: _____ **ID#** _____ **Date:** _____

☐ Copy sent to physician on: (date) _____

CLINICAL CHART

Discharge Summary Completion Guidelines:

1. Initiate this form in the event a patient is discharged from service.
2. List all diagnoses that were treated, therapies provided and dates of service.
3. Document access device(s) in place at time of discharge.
4. Enter Reason for Discharge Code, selecting from the following:

HEU	Home environment unsuitable
INSDIR	Insurance directed
LOCG	Lack of caregiver
MOOA	Patient moved out of service area
NONCOMP	Noncompliance or safety issue
NRT	Not responsive to therapy
OTHER	Other
PDCSR	Patient decision - Customer service related
PDTR	Patient decision - Therapy related
PHYDIR	Physician directed
SVCCMP	Service completed
TR	Transplant received
TRCOMP	Pt. transferred to another company location
UMPN	Coram unable to meet patient needs.

5. Summarize Clinical Services and care provided.
6. Indicate any Discharge Instructions provided to the patient and/or caregiver.
7. Sign and date the form, indicating completion.
8. Fax completed form to physician.

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