



Addressograph

DISCHARGE PLANNING ASSESSMENT TOOL

Admission Date:

Diagnosis:

Unit:

Bed No.:

Part 1 Adopted from Blaylock's Risk Assessment Tool

Risk Factors

| | |
|---|---|
| <p>Age 0 = 55 years or less 1 = 56 to 64 years 2 = 65 to 79 years 3 = 80 + years</p> | <p>Behavior Pattern 0 = Appropriate 1 = Wandering 1 = Agitated 1 = Confused 1 = Other</p> |
| <p>Living Situation/Social Support 0 = Lives only with spouse 1 = Lives with family 2 = Lives alone with family support 3 = Lives alone with friend's support 4 = Lives alone with no support 5 = Nursing home/residential care</p> | <p>Mobility 0 = Ambulatory 1 = Ambulatory with mechanical assistance 2 = Ambulatory with human assistance 3 = Non ambulatory</p> |
| <p>Cognition (spheres = person, place, time and self) 0 = Oriented 1 = Disoriented to some spheres some of the time 2 = Disoriented to some spheres all of the time 3 = Disoriented to all spheres some of the time 4 = Disoriented to all spheres all of the time 5 = Comatose</p> | <p>Sensory Deficits 0 = None 1 = Visual or hearing deficits 2 = Visual and hearing deficits</p> |
| <p>Functional Status 0 = Independent in ADLs & Instrumental (Is) activities Dependent in 1 = Eating/feeding 1 = Bathing/grooming 1 = Toileting 1 = Transferring 1 = Incontinent of bowel function 1 = Incontinent of bladder function 1 = Meal preparation (Is) 1 = Responsible for own medication administration (Is) 1 = Handling own finances (Is) 1 = Grocery shopping (Is) 1 = Transportation (Is)</p> | <p>Number of Previous Admissions/A&E Visits 0 = None in last 3 months 1 = One in last 3 months 2 = Two in last 3 months 3 = More than two in the last 3 months</p> <p>Number of Active Medical Problems 0 = Three medical problems 1 = Three to five medical problems 2 = More than five medical problems</p> <p>Number of Drugs 0 = Fewer than three drugs 1 = Three to five drugs 2 = More than five drugs</p> |

Total Score: **Assessed by (Physician name & signature):** **Date:** **Time:**

Risk Factor Index: If score is 10 or greater, the attending physician will refer the patient to the relevant disciplines (Community Nurse, Dietitian, Social Worker, etc.).

Part II Discharge Risk Assessment Tool

| Patient | Problems |
|--|-----------------|
| 1. Can read <input type="checkbox"/> yes <input type="checkbox"/> No | |
| 2. Speaks and under stands <input type="checkbox"/> English <input type="checkbox"/> Arabic Urdu <input type="checkbox"/> Hindi <input type="checkbox"/> Farsi <input type="checkbox"/> Other Specify _____ | |
| 3. Has barriers to learning <input type="checkbox"/> yes <input type="checkbox"/> No (refer to Patient / family Education Tool) | |
| 4. Understands: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Reason for Hospitalizati <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Diagnose and Prognosis <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Signs and Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Complications <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Diet <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Medication (purpose and side effects) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 5. Has cognitive deficits related to medical management at <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 6. Has sensory deficits related to medical management at home (task, smell, vocalization /verbalization, manual, dexetrity) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7. Has behavirol deficits related to medical management at home <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. Has mobility deficits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 9. Has functional and / or instrumental ADL that may be affected <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| HEALTH | Problems |
| 10. Can patient manage these conditions / problems after discharge <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. Does client need care / education for the discharge <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. Does family / significant other need assistance / education <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ENVIRONMENT | Problems |
| 13. Will clients home environment be affected by medical management after discharge <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 14. Will family / significant others environment be affected by medical management after discharge. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 15. Will clients work environment be affected by medical management after discharge <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| RESOURCES | Problems |
|--|-----------------|
| 16. Will clients income be affected due to current health status <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 17. Does client have the means to pay for any expenses <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 18. Does the family/significant other have means to pay for any expenses <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 19. Will the client be able to use his/her usual means of transportation <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 20. Does client have access to alternative source of transportation <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 21. Does the client have access to assistance from community sources (clinics, organaizations) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 22. Does the client have a support network if yes, specify name / relationship. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 23. Do the people regarded as the clients support network accept this role <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24. Do the family /significant other/support network have fears or concerns <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Does the client have any concerns about discharge that have not been identified. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 26. Can the family / significant other/ support network offer solutions to any of the problems <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 27. Can the client give any solutions to his discharge problems <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Assigned Nurse: _____

Date: _____

This assessment has been discussed with me and I understand the problems, which will affect my discharge. I also understand that as soon as these problems are resolved the discharge will take place.

Patient: _____ **Support Person/Next of Kin:** _____

Relationship to patient: _____

Referred to: _____ **Date:** _____ **Time:** _____

_____ **Date:** _____ **Time:** _____

_____ **Date:** _____ **Time:** _____



DISCHARGE PLANNING ASSESSMENT TOOL

Addressograph

Multidisciplinary Discharge Plan

Attending Physician

Prognosis and Plan: _____

Expected Date of Discharge: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Assigned Nurse

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Physiotherapist

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Social worker

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Dietician

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Community Nurse

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Pharmacist

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

Other Disciplines:

1. Speciality: _____

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

2. Speciality: _____

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

3. Speciality: _____

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

4. Speciality: _____

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |

5. Speciality: _____

Plan: _____

Name & Signature: _____ Date: _____ Time: _____

| Date | Problems Identified | Action Plan | Responsible Person | Time frame | Date Resolved | Initial |
|------|---------------------|-------------|--------------------|------------|---------------|---------|
| | | | | | | |