

Discharge Checklist Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Name: \_\_\_\_\_ Room #: \_\_\_\_\_

**Not part of the medical record:** If found, return this form to D/C unit's Nurse Manager.

Yes	No	NA	Nursing:	Comments
			*Normal Vitals ( <i>document abnormalities</i> )	
			*Normal FSBS ( <i>document abnormalities</i> )	
			Foley D/C'd	
			*Voiding appropriately	
			Access D/C'd (applies to IV, PICC or Central L)	
			O <sub>2</sub> D/C'd	
			*BM within last 24 hours	
			Educational needs met	
Yes	No	NA	Testing:	Comments
			*AM- Lab work collected & resulted	
			*AM- Radiology studies completed & resulted	
Yes	No	NA	Home Care:	Comments
			Preauthorizations obtained (meds/equipment)	
			Home O2 set up	
			Home Care Services Arranged	
Yes	No	NA	Paperwork:	Comments
			Discharge printed & placed in pocket of the chart	
			Prescriptions obtained	
Yes	No	NA	Discharge:	Comments
			Transportation Arranged	
			Family/S.O. notified of D/C time	
			Patient's home medications from pharmacy	
Yes	No	NA	Other Tasks: fill as needed	Comments

Before noon                       ^noon-5pm                       ^after 5pm                       ^did not leave that day

^Comment of why Patient left after 12 noon: \_\_\_\_\_