IMPACT DISCHARGE ORDERS

Patient Name____ DOB____________________

Discharge Date______________________________ Discharge Disposition____________________

Home Care ☐RN ☐PT ☐OT ☐CNA Agency: ☐UPAH ☐ OTHER_____________

DME ☐Walker ☐Wheelchair

☐Standard ☐Standard weight

☐Heavy duty ☐Lightweight

☐Front wheeled ☐Heavy duty

☐4 wheeled with seat ☐Accessories_______________

☐Accessories __________ Patient weight and height________________

☐ Oxygen ☐Hospital bed ☐Commode ☐Nebulizer

☐Delivery method ☐Qualifying DX___________

☐LPM__________ ☐accessories____________

(Trapeze, pressure reductions mattress)

Pharmacy __________________________ (IF VA or mail in, identify alternative pharmacy)

RX needs____________________________ (Please clearly identify on the *CURRENT* MAR)

Meds Reviewed with patient _________ (Please Initial)

Labs

☐INR Date_____________ ☐ Other _____________ Date______________

Special Discharge Instructions:

____

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Follow Up Appointments

PCP____ Date/Time________________

Specialty____ Date/Time________________

Provider Signature____ Date__________________

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Provider Signature____ Date___________________