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| --- | --- | --- | --- | --- |
| **COMPLEX DISCHARGE- Select reason from below – Notify** | | | | |
| Likely to require an increase in care package – reason :  Current package:  Current care provider:  Contact no: | | | | |
| Likely to require a new care package – reason: | | | | |
| Patient and or family expressing concerns about discharge—details: | | | | |
| **ACTIONS REQUIRED TO SUPPORT DISCHARGE** | | | | |
| **What needs to happen so that this patient can leave hospital** | **Who is responsible** | **By when** | **Date completed** | **Signature** |
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| **Free text notes** | | | | |

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| --- | --- | --- | --- |
| Free text notes | | | |
| Pre discharge checklist | Date | Time | Initials |
| Agreed medically fit for discharge |  |  |  |
| PT assessed safe for discharge |  |  |  |
| OT assessed safe for discharge |  |  |  |
| Care provider notified |  |  |  |
| NOK notified |  |  |  |
| Transport arranged  Own/ ambulance Booking no: |  |  |  |
| CDD and medications given and explained |  |  |  |
| Cannula removed |  |  |  |