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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  |  |  |  |