Affix Patient information label HERE

Hospital Discharge Summary (HODS)
&
Psychiatrist's - Discharge Summary (PYDS)

Completion Checklist

☑ Tick box if completed

- ❑ **Patient Discharge follow up Consent** – signed
- ❑ **Medical-HODS** **(page 1 of 3)** - CMO/ Registrar/ VMO
- ❑ **Medications- HODS** **(page 2 of 3)** - CMO/Registrar/ Pharmacist
- ❑ **Psychosocial- HODS** **(page 3 of 3)** - Nursing/ Allied Health Carer
- ❑ **Psychiatrist's Discharge Summary-** VMO/ Registrar
  (send only if completed and signed)

Patient given a PHOTOCOPY **of**

- □ Medications- HODS
- □ Psychosocial - HODS

- ❑ **Fax cover sheet details completed**
- ❑ **Attach additional reports as requested**
- ❑ **Report written in patient progress notes if 'not faxed'**

e.g. ► No consent ► Fax unsuccessful ► No/ incorrect referrer details

FAX STAMP with date HERE
(when documents confirmed sent)

Revised Add Date. ***File in Medical Record as part of Discharge Documentation package***

Form MR

Organisation logo here

FACSIMILE – PRIVATE & CONFIDENTIAL

URGENT MEDICAL INFORMATION - Please ensure a doctor reads this fax within 48 hours of receiving

Date:	
Send to:	From:
Attention:	Phone Number:
Fax Number:	Number of Pages, Including Cover:
SUBJECT - Patient's Hospital Discharge Summary & Reports	

____

____

____

____

Reports and Results (þ Tick box & including number of pages for each item):

- ☐ Medical -Hospital Discharge Summary – (1)
- ☐ Medications - Hospital Discharge Summary – (1)
- ☐ Psychosocial - Hospital Discharge Summary – (1)
- ☐ Psychiatrist's Discharge Summary (1)

☐ Pathology Results [Circle included items: Biochemistry / Haemotology / Drug levels] No. Pages ___

Other or Comment: ______________________________

☐ Radiology Reports [Circle included items – X-Ray / CT Scan / Ultrasound] No. Pages ____

Other or Comment: ______________________________

☐ Other (specify): __________________________ No. Pages ____

☐ Other (specify): __________________________ No. Pages ____

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

DISCHARGE FOLLOW UP CONSENT

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DISCHARGE FOLLOW UP CONTACT - CONSENT

Authority for Discharge Nurse to contact my Health Care Professionals

I hereby authorise the Discharge Nurse of (Organisation's name) to contact my Health Care Professional (GP, Psychiatrist, and/or Case Manager) to provide health information related to my discharge. No information will be disclosed unless it has been previously discussed with me. ***Please note***, in life threatening situations we are obliged to provide necessary information to health care providers without your consent.

☐ **General Practitioner** Name: ______________________ Phone No.: ________________

Fax No: ________________

Address: ____

☐ **Other Health Professionals** (e.g. Psychiatrist, Nurse, Social Worker, Psychologist)

Name: ______________________ Phone No.:________________

Fax No: ________________

Address: ____

☐ **Authority for the Hospital Pharmacist to contact my regular community pharmacist.**

Pharmacy Name: ______________________ Phone No.: ________________

Address: ____

☐ **I consent to the Discharge Nurse contacting me after I am discharged.**

Home Phone: ______________________ Mobile Number: ________________

Email: ____

Can the Discharge Nurse leave a discrete message ☐ Yes ☐ No

Patient Signature: ______________________ Date: _____/_____/_____

Witnessed by: ______________________ Date: _____/_____/_____

If you do not consent to any of the statements, cross out that statement.

This consent form is valid for a period of 12 months from the date of this form being signed.

PSYCHIATRIST'S DISCHARGE SUMMARY

**Note: A typed copy of the Psychiatrist's final discharge letter will be forwarded via regular mail.*

Affix patient information label here

Date of admission:_____/_____/_______ Date discharge: _____/_____/_______

Diagnosis (DSM-IV)

Axis 1: ____________________

Axis 2: ____________________

Axis 3: ____________________

____

History - Presenting Problem(s) and Mental state

In Hospital Progress and Treatment

Medications ceased this admission

Summaries to: (tick box if faxed at discharge)

☐ ____________________

☐ ____________________

Signature: ____________________

Date: _____/_____/__________

PSYCHIATRIST'S - DISCHARGE SUMMARY

BINDING MARGIN — DO NOT WRITE

HOSPITAL DISCHARGE SUMMARY

Affix Patient Information Label HERE

Instructions - Medical Officer to complete pages 1 and 2 (Medications); Pharmacy page 2 (sign/date); Nursing staff to complete page 2 Community pharmacy and Webster pack details, and page 3 - complete all sections prior to faxing within 12hrs to 48hrs of patient discharge.

VMO:_______________________________________ Psychiatrist's Discharge Summary to follow (within 2 weeks)

Admission Date: ______/______/_________ Discharge Date: ______/______/_________

Reason for Admission: ____

Referral by (☑ relevant item) ☐ GP ☐ Psychiatrist ☐ Transfer from another hospital ☐Allied Health Clinician

☐Community Mental Health Team ☐ Self-presentation ☐ Other (specify) ____________________________

Mode of Discharge: (☑ relevant item) ☐ Planned ☐ Unplanned discharge due to breach of contract

☐ Early Discharge VMO Approval ☐ Transfer to another hospital ☐ Self-discharged against medical advice

Diagnosis (Axis) (for this episode of care): 1. ____

2. ____

3. ____

New Physical findings and Test results **(Reports attached Tick box ☑ if relevant)**

____

____

____

____

Medical follow-up required (For example: Urgency of GP follow-up, repeat tests, Non-psych Specialist management required, etc.)

____

____

____

Alerts **(☑ all relevant items)** ☐No Alerts ☐Suicide - history ☐Self-Harm ☐Substance abuse ☐Falls risk

☐Harm to Others ☐Cognitive impairment ☐Medical Allergy ☐Aggression ☐Other ____________________

Comment: ____

Next treatment phase (**☑ all relevant items**)

☐General Practitioner follow-up ☐Psychiatrist follow-up ☐ Day Program ☐Discharged at own risk

☐Community Mental Health Care follow-up ☐Webster medications pack ☐Other (specify) _________________

☐Transfer to another hospital (reason) : ____

Medical Officer's Signature: ________________________________ Designation VMO / Registrar / CMO

(circle relevant response)

Print Name: ___________________________________ Date: ________________

HOSPITAL DISCHARGE SUMMARY — MEDICAL

BINDING MARGIN — DO NOT WRITE

BINDING MARGIN — DO NOT WRITE

Allergies & Adverse Reaction: ☐ Nil Known ☐☐ Unknown ☐ See below
(Please ☑ relevant box or list)

Affix Patient Information Label HERE

Name of medication	Strength	Morning	Midday	Evening	Bedtime	Purpose	Script given/ Special instructions

PRN - (Take only when needed medications)	PRN
PRN	PRN

Medical Officer's signature : ________________ Date: __________ Print name: ________________ VMO or Registrar or CMO

Patient has consented to community pharmacy contact? Yes / No / Not documented (circle response)

Patient had a Webster pack on admission **or** Webster pack requested for discharge (circle response)

Community Pharmacy contact details	Name	Phone:	Fax:	Date contacted:
Pharmacist's signature (when form completed)		Date signed:		

HOSPITAL DISCHARGE SUMMARY - MEDICATIONS

Preferred language: ____________________

Interpreter (☑ relevant item) ☐ Required ☐ Not Required

Assessments on Admission & Discharge (☑ all relevant items—complete details if required)

Health of the Nation Outcome Scales (HoNOS) total score on: Admission ______ Discharge: ______ N/A

Edinburgh PND scale: ☐ On Admission: ________ On Discharge: ________ N/A

Summary of care given: (☑ all relevant items—complete details if required)

☑ Nursing care ☐ Living skills / Rehab ☐ ECT

☐ Group CBT ☐ Diversional ☐ Pharmacotherapy

☐ Group DBT ☐ Detoxification ☐1:1 Counselling

☐ Group Psychoeducation ☐ Psychotherapy other (specify):____________________

☐ Other (specify) ____________________

Summary Social Issues (☑ all relevant items—complete details if required) ☐ No Social Issues identified

☐ ACAT Assessment - date: / / ☐ Centrelink ☐Pastoral Care Support

☐ Dept. of Housing ☐ Other (specify) ____________________

Comment(s) ____________________

Accommodation on discharge (☑ relevant item)

☐Own House/ Flat ☐Relative's House /Flat ☐Rented ☐Residential Care ☐Nursing Home ☐Hospital ☐Crisis accommodation ☐ Other (e.g. Hostel) (specify) ____________________ or ☐Unknown

Accommodation contact phone number: ____________________

Discharge Goals (Refer to patients discharge planning book and write one Short term and Long term goal)

____

____

____

____

Follow-up appointments confirmed (Psychiatrist, GP, ECT, Counselling or Therapy Programme, Psychologist, D/C nurse, etc.)

With:__________ Location:__________ Date:__________ Time:__________

With:__________ Location:__________ Date:__________ Time:__________

With:__________ Location:__________ Date:__________ Time__________

I have read and understood this discharge summary and I have received my Future plan (i.e. information pack).

Patient's signature:____________________ *or* Carer signature:____________________

Caregiver's Signature: ____________________ Date:__________

Caregiver print first name: ____________________Designation: __________(e.g. Nurse)

This section to be completed by the person responsible for ensuring the completed Hospital Interim Discharge Summary (HIDS) is sent to the patient's Referring practitioner

Copies also sent to the patient's: ☐**GP** ☐**Psychologist** ☐**CMHT** ☐**Psychiatrist**

☐**Other** (specify):____________________

BINDING MARGIN — DO NOT WRITE

HOSPITAL DISCHARGE SUMMARY - PSYCHOSOCIAL