Shuree Home Healthcare, Inc.
4492 W. Lawrence Ave.
Chicago, IL 60630
Phone: (773) 283-4950 | Fax: (773) 283-4980

SN DISCHARGE SUMMARY

Patient Name: **MRN:** **DOB:** **DC Date:**

Episode: **Summary Date:** **Patient Notified of Discharge:**

Reason for D/C:

Primary DX:

Secondary DX:

Physician: **Physician Phone:** **Physician Fax:**

Patient Condition and Outcomes

☐ Stable	☐ Improved	☐ Unchanged	☐ Unstable
☐ Declined	☐ Goals Met	☐ Goals Not Met	☐ Goals Partially Met

Service(s) Provided

☐ SN	☐ PT	☐ OT	☐ ST
☐ MSW	☐ HHA	☐ Other _____	

Care Summary: (Care Given, Progress, Regress Including Therapies)

Condition of discharge (Include VS, BS, Functional and Overall Status)

Discharge Disposition: Where is the patient after discharge from your agency?

☐ 1 – Patient remained in the community (without formal assistive services)
☐ 2 – Patient remained in the community (with formal assistive services)
☐ 3 – Patient transferred to a non-institutional hospice
☐ 4 – Unknown because patient moved to a geographic location not served by this agency
☐ UK – Other unknown

Discharge Instructions Given To:

☐ Patient ☐ Caregiver ☐ N/A ☐ Other _____

Clinician Signature: **Date:**

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SN DISCHARGE SUMMARY

Patient Name: **MRN:** **DOB:** **DC Date:**

Episode: **Summary Date:** **Patient Notified of Discharge:** No

Reason for D/C:

Primary DX:

Secondary DX:

Physician: **Physician Phone:** **Physician Fax:**

Discharge Instructions

Verbalized understanding ☐ Yes ☐ No

☐ All services notified and discontinued ☐ Order and summary completed

☐ Information provided to patient for continuing needs ☐ Physician notified

Clinician Signature: **Date:**