Ascendi Home Health Agency

DISCHARGE INSTRUCTIONS

Patient Name:
____MR#.______________________
We at Ascendi Home Health Agency are pleased to have provided you with service.
The following discharge instructions were reviewed with you and/ or your caregiver during the final visit(s) by our home health staff. If you have any questions concerning these instructions, please call **(305)264-7574.** We hope that if you need home health services in the future, you will choose us again. **You are to:**

- ☐ **Keep your scheduled and follow-up appointments with Dr.** ______________________
- ☐ **Take your medications as prescribed by your physician and instructed by your nurse.**
- ☐ **Follow the diet/fluids restrictions as prescribed by your physician and instructed by your** nurse:____
- ☐ **Continue with skin/wound care as instructed by your nurse.**
- ☐ **Continue with home exercise program/safety instructions as instructed by your therapist(s).**
- ☐ **Continue to use the assistive device(s) adaptive equipment as instructed by your therapist(s).**

Physician should be contacted if any of the following signs and symptoms are experienced-

- Temperature over 101 F for more than 24 hours
- Severe pain not relieved by medications already ordered by your physician
- Active bleeding from a wound or body cavity
- Reaction to any medication (allergy/adverse reaction/side effects)
- Nausea and vomiting (more than twice in one day)
- Dizziness, confusion, unsteady balance, blurred or double vision
- Fall or trauma/injury

☐ **Emergency Services (9-1-1) should be contacted if any of the following are experienced:**

- Difficulty breathing, severe shortness of breath.
- New onset of pain, especially severe/unrelieved chest pain, jaw pain, arm pain, or feeling of indigestion accompanied by nausea and sweating
- Change m behavior and/or mental status, loss of consciousness
- Excessive bleeding/hemorrhage

IN CASE OF MEDICAL EMERGENCIES OR LIFE THREATENING SITUATIONS INCLUDING FIRECALL 9-1-1

- Other instruction: ____

____.

Instructions given by phone - YES - NO Date:____________________

________________________________ ____________

Nurse/Therapist Name/Title/Signature Date