Vancouver CoastalHealth

MY DISCHARGE PLAN

Hospital Site: ☐ **VGH** ☐ **UBCH** ☐ **GFS**

PCIS LABEL

I was **ADMITTED** to hospital on: _____ I was **DISCHARGED** on: _____

My **DOCTOR** in Hospital was: _____ The **UNIT** I was discharged from was: _____

My **FAMILY Doctor** is: _____ **FAMILY Doctor** telephone #: _____

Other Doctors involved in my care are: (Specify Name & Specialty)

1. _____ 2. _____ 3. _____

The **REASON** I was in hospital is: _____

The MEDICAL WORD for this condition is: _____

I also have these other conditions:

_____ _____

_____ _____

_____ _____

Some of my tests were:	My tests showed:
_____	_____
_____	_____
_____	_____

Some of my treatments were:	The reason for these treatments were:
_____	_____
_____	_____
_____	_____

I have these Allergies: _____

My Health care team recommends these lifestyle changes:

Smoking: _____ Diet : _____

Smoking Cessation Hot Line: 1-877-455-2233; or visit: Quitnow.ca

Activity: _____

Alcohol: _____

MEDICATIONS

New/Changes:

_____ _____ _____

_____ _____ _____

Old medications to be continued:

_____ _____ _____

_____ _____ _____

Old medications to be **STOPPED:**

_____ _____ _____

_____ _____ _____

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My Follow-up TESTS are:	Location	Date	Time	Phone #	How am I going to get to my tests?

My Follow-up APPOINTMENTS are:	Location	Date	Time	Phone #	How am I going to get to my appointments?

When I leave the Hospital and go Home, I will be supported by:

Service	**Agency Name & Phone Number**	**Appointment Date/Time**
Home Care Nursing		
Home Case Manager		
Home Care Occupational/ Physiotherapy		
Mental Health Team		
Community Health Centre		
Home Support / Personal Care		
Equipment		
Meal Service		
Other		
Other		
Other		

I need to call my Family Doctor right away if these warning signs occur:

_____ _____

_____ _____

******Call 9-1-1 if you need emergency assistance******

****Call 8-1-1 Health Link BC - Nursing Services - if you have a medical question**** ***(Hearing-impaired: 7-1-1)***

If I have any questions about the above information **within 48 hours of arriving home**, I can contact the following person between **9:00am and 4:00pm**:

Monday - Friday CML Name: _____ Phone #: _____

Saturday & Sunday: Transitional Services Team Office Phone #: 604-875-4945

Discharge Plan Faxed to: ☐ Family Physician ☐ Transition Services Team ☐ Other(s): _____