ONLYSERVE HOME HEALTH

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DISCHARGE INSTRUCTIONS

Patient Name:	Date:
Medical Record No:	

DISCHARGE MEDICATIONS

Medication Name	Dose (Amount)	Route (How to take)	Frequency (How often)	Comments

- ❑ Make a follow-up appointment with your MD within one (1) to two (2) weeks or as needed.
- ❑ Call 911 in case of emergency such as chest pain, shortness of breath, signs and symptoms of stroke or bleeding, possible heart attack, pain not relieved by pain medication.
- ❑ Comply with current treatment.
- ❑ Comply with medications listed above, take as ordered
- ❑ Others: ____

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❑ Patient/Caregiver demonstrates/verbalizes understanding of discharge medication/instructions.

I acknowledge receipt of the above discharge medication/instructions.

______________________________ ______________________________
Patient / Representative Signature Staff Signature

First Copy – Clinical Chart **Second Copy – Patient**