

Care New England

- Butler Hospital Kent Hospital
 Women & Infants Hospital of RI
 VNA of Care New England

Rhode Island Department of Health Continuity of Care Form

Patient Name: _____

Home Address: _____

Being discharged to: _____

Address _____

Phone: _____

Discharging Facility: _____

Contact Person: _____

Phone/Beeper: _____

Insurer: _____

Number: _____

Inpatient - Admission Date: _____ Discharge date: _____

Referral to: _____

Phone: _____

Patient demographic/registration sheet must be attached.
 Copy of most recent lab results must be attached.
 Copy of medications and IV sheets

For NH:
 Other Facilities

SHADED AREAS TO BE COMPLETED BY PHYSICIAN

PRINCIPAL DIAGNOSIS OF THIS ADMISSION:

SURGERY THIS ADMISSION: DATE:

Does the patient have an Advance Directive?

No Yes FULL DNR CMO

IMMUNIZATION(S) this admission:

FLU PNEUMOVAX

TUBERCULIN STATUS, if known:

NEG POSITIVE UNKNOWN

Allergies, list and describe reactions:

OTHER ACTIVE MEDICAL PROBLEMS:

INFECTIONS THIS ADMISSION AND SITE:

	Active	Resolved Date	Prior History
MRSA			
VRE			
C. Diff.			

Physician orders/treatments. Please specify number and frequency.

Diet: _____ Condition at Discharge: _____

Activity: _____ Improved

Unchanged

Nursing Assessment

PT _____ /wk

OT _____ /wk

ST _____ /wk

Oxygen- _____ l/min _____ hours/day

All medication(s) to be taken post discharge including those taken prior to admission: