Sláinte Leanaí Éireann ag Cromghlinn
CHI
Children's Health Ireland at Crumlin

INFANT & CHILD
DISCHARGE PLANNING

Full Name: ……………………
Address: …..
HCR. ……..
Please insert addressograph ………………… ……………………………………

DISCHARGE PLANNING

	Yes	*No*	*Please specify or provide further details, put in dates*
Education commenced / Information Leaflets given			*Please specify what Parent Information Leaflets*
Relevant pharmacy education given			
Local pharmacy contacted			
Patients own medication returned *(i.e. nebs, meds, EBM)*			
Prescription given			
IV Cannula removed			
Skin integrity intact			
PHN letter commenced			Collection Yes □ No □ Posted Yes □ No □ Faxed Yes □ No □
Community Outreach Nurse contacted			
Equipment ordered *Please specify*			
Transfer letter			
Discuss discharge with child / parent / guardian			
Know when he/she can return to normal activities and to school			
Parents understand their child's condition and care relating to same.			
Know when to seek advice if concerns after discharge			
Other *(MSW, CNSp)*			

Follow up appointments *Give dates:*

Discharge – Complete this section 24-72 hours prior to Discharge

Transport required Yes □ No □ **Date:** ……………………………….

Type of transport Ambulance □ Minibus □ Taxi □ Own Transport □

Transport Booked Yes □ No □ Date: ………………………… Ref No:

Discharge arrangements confirmed with Patient / Guardian: Yes □ No □

Additional Information / Advice Given

Nursing Student *(Print Name):* …………………………………………………… **Signature:** ……………………………………………………**NMBI:** ……………………………

Registered Nurse Name *(Print Name):* ……………………………………………… **Signature:** ……………………………………………………**NMBI:** ……………………………

D I S C H A R G E