




DISCHARGE RISK ASSESSMENT - to be completed at 2 days prior to discharge

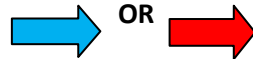
CHECK ALL THAT APPLY

- Lives at home with limited or no community support
- Requires assistance with medication management
- Polypharmacy (more than 7 medications)
- History of mental illness
- Issues with health literacy
- Requires assistance with ADLs/IADLs
- Cognitive impairment
- End stage conditions** 
- Diagnosis of CHF/COPD/DM/HIV-AIDS
- Incontinent
- Acute/chronic wound or pressure ulcer
- History of falls
- Decreased adherence to treatment plan
- Repeat hospitalization / ED visits
- Requires assistance with managing O2 and/or nebulizer

Total # checked _____

Score ≥ 5

The patient is **HIGH RISK** for re-hospitalization. **Refer to Home care service, SNF, or Hospice.**



Score 2-4

The patient is **MODERATE RISK** for re-hospitalization. **Refer to Home care service prior to D/C.**



Score < 2

The patient is **LOW RISK** for re-hospitalization. **Discharge home.**



NOTIFY AGENCIES UPON COMPLETION:



HOME HEALTH AGENCY NAME / NOTIFIED

Called DATE/TIME _____

FAX'd DATE/TIME _____



SKILLED NURSING FACILITY NAME / NOTIFIED:

Called DATE/TIME _____

FAX'd DATE/TIME _____



HOSPICE NAME / NOTIFIED:

Called DATE/TIME _____

FAX'd DATE/TIME _____

PCP NAME / NOTIFIED:

Called DATE/TIME _____

FAX'd DATE/TIME _____

COMPLETE BY _____

DATE/TIME _____

Patient Sticker