Discharge Instructions Record: Emergency Department

Your Emergency Visit summary:

Medication Prescription Provided	☐ Yes	☐ No	☐ N/A	Comments:
Medication(s) Reviewed:	☐ Yes	☐ No	☐ N/A	
Medication from Home Returned:	☐ Yes	☐ No	☐ N/A	

Teaching Provided: ☐ Yes ☐ No ☐ N/A If yes, indicate applicable one(s)

☐ Head Injury ☐ Wound Care ☐ Fever Care ☐ Vomiting/Diarrhea
☐ Cast Care ☐ Falls Risk Prevention ☐ VTE Risk Prevention ☐ Procedural Sedation
☐ Use of Crutches ☐ Other (if yes, list): _____

_____

What to do at home to manage your condition(s) and stay healthy:

Call **Health Links – Info Santé** anytime, at **204-788-8200** or toll-free **1-888-315-9257**, for questions about your health or if symptoms re-appear or worsen. They will guide you to the care you need.

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Follow-up Appointments &/or Referrals (list date, time, location, purpose).

You are a Home Care Client: ☐ Yes ☐ No
If yes, please share this information with your Case Coordinator

Your **vital signs** were: BP P R T

You have your **belongings**: ☐ Yes ☐ No ☐ N/A

Information Reviewed With : ☐ Patient ☐ Family ☐ Other:

Leaving the emergency department (how and with whom):

Completed By: Signature: Date:

NB: Original to be sent with patient or family. Copy to remain on chart.