Bloomington Hospital
Bloomington, Indiana

Neuroscience Services
STROKE AND TIA DISCHARGE ORDERS

ADMINISTRATIVE

☒ Discharge Patient

DISCHARGE DIAGNOSIS ____________________

DIAGNOSIS/SYMPTOMS

1. ☐ Ischemic Stroke
2. ☐ TIA
3. ☐ Hemorrhagic
4. Risk Factors/Co-Morbidities:
   - ☐ Tobacco Use ☐ Diabetes ☐ Sedentary Lifestyle
   - ☐ Hyperlipidemia ☐ Family History ☐ Atrial Fibrillation
   - ☐ Hypertension ☐ Obesity ☐ Obstructive Sleep Apnea
5. ☐ ____________________

CONSULTS	Start Date	Locations
1. ☐ Stroke Rehab (Outpatient Cardiac Rehab)	________	________
2. ☐ Diabetes Center	________	________
3. Outpatient Medical Nutrition Therapy	________	________

- ☐ (Dietary Survellience & Counseling (V-65.3)
  To schedule appointment: Fax referral to (812) 353-9606, then call 800-978-9600
- ☐ Hyperlipidemia (272.4)
- ☐ Hypertension (401.9)
- ☐ Obesity/Weight Management (278.00 unspecifed)
- ☐ ____________________

4. ☐ Overnight Polysomnogram
5. ☐ Anticoagulation Therapy Referral
6. ☐ Stroke Survivor Support Group
7. ☒ If tobacco user, Tobacco Cessation Counseling (Prior to discharge)
8. Post Acute Rehabilitation Needs:

	Occupational Therapy	Physical Therapy	Speech Therapy
☐ Home Health	☐	☐	☐
☐ Outpatient	☐	☐	☐
☐ Acute Rehab	☐	☐	☐
☐ ECF	☐	☐	☐

Entered by ________ Date ______ Time ______

Noted by ________ Date ______ Time ______

________ ☐ M ☐ F ______
Patient-Last Name, First Name, Middle Initial Age

Admission Number ______ Date ______ Birth Date ______

Physician Name ____________________

Patient Identification

Medical Record Number ______ Physician Signature ______ Date ______ Time ______

NURSING

ACTIVITY

1. ☐ No restrictions
2. ☐ No driving until ______________
3. ☐ Lifting restriction ______________
4. ☐ As tolerated
5. ☐ Assistive device ______________

DIET

1. ☐ Low Sodium _____ gms/day
2. ☐ Low Cholesterol
3. Consistency Modifications
   Dysphagia Level: ☐ Puree ☐ Mechanically Altered ☐ Mechanical or Dental Soft ☐ Advanced
   Liquid Consistency: ☐ Nectar-Thick Liquids ☐ Honey-Thick Liquids ☐ Thin Liquids
4. ☐ Carbohydrate Controlled Diet (per day): ☐ 150 gm ☐ 200 gm ☐ 250 gm ☐ 300 gm
5. ☐ Tube feeding formula _______________ Bolus volume ______ # Bolus per day ____
   Times ______ ______ ______ ______
   Continuous feeding rate ______ mL/hour for _____ hours/day Time ____________
   Water flushes ____
6. ☐ ____

CARE NEEDS

1. ☐ Skin/wound care ____
2. ☒ Give appropriate stroke education booklet
3. ☒ Confirm patient has received the following vaccines per protocol (if appropriate)
   Vaccines: Influenza Vaccine (During September – March)
   Pneumococcal Vaccine

CALL CRITERIA

☐ ____

MEDICATIONS (See Reconciled Discharge Medication Orders)

Document contraindications to medication classes below if not ordered.

☐ Ordered	**Aspirin**	☐ Intolerance/allergy	☐ Bleeding	☐ ____________
☐ Ordered	**Anticoagulant** (A Fib)	☐ High risk for bleeding	☐ Fall Risk	☐ ____________
☐ Ordered	**Platelet Aggregation Inhibitor**	☐ High risk for bleeding	☐ N/A	☐ ____________
☐ Ordered	**Statin**	☐ Liver Dysfunction	☐ Rhabdomyolysis	☐ ____________

Entered by ________________ Date ________ Time ______

Noted by _______________ Date ________ Time ______

_________________________________ ☐ M ☐ F _________
Patient-Last Name, First Name, Middle Initial Age

_______________ _______________ _______________
Admission Number Date Birth Date

____
Physician Name

Patient Identification

_______________ Medical Record Number

_______________________________ _________ _________
Physician Signature Date Time

FOLLOW UP APPOINTMENTS

Dr. _______________ Phone_______________ Make appointment to be seen in __________ ☐ Call physician to make appointment

Dr. _______________ Phone_______________ Make appointment to be seen in __________ ☐ Call physician to make appointment

Dr. _______________ Phone_______________ Make appointment to be seen in __________ ☐ Call physician to make appointment

Dr. _______________ Phone_______________ Make appointment to be seen in __________ ☐ Call physician to make appointment

CLEARED FOR DISCHARGE

This box is not to be completed until the patient is ready to be discharged.
If taking a verbal/telephone order, it must be documented as "read back" and "verified".

Physician Signature __________________________ Date _____/_____/____ Time _____________

Fax a copy of discharge orders and reconciled medication list to the following care providers _______________

Please remove patient armband at time of discharge

Entered by _______________ Date _______ Time ______

Noted by ______________ Date _______ Time ______

_________________________________ ☐ M ☐ F _________
Patient-Last Name, First Name, Middle Initial Age

_______________ _______________ _______________
Admission Number Date Birth Date

____
Physician Name

Patient Identification _______________ Medical Record Number

_________________________________ _________ _________
Physician Signature Date Time