



0400002

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

“WE’RE GOING HOME” FOR _____ FAMILY DISCHARGE INSTRUCTIONS
IF TRANSFERRED, THIS FORM SHOULD ACCOMPANY THE BABY.

Family Name/ Relationship	RN		RN		My family is comfortable: (Date when completed).
	Init.	Date	Init.	Date	
					Changing my diaper
					Taking my temperature (including reading thermometer)
					Giving me a bath <input type="checkbox"/> sponge <input type="checkbox"/> tub
					Feeding me <input type="checkbox"/> breast <input type="checkbox"/> bottle <input type="checkbox"/> making formula <input type="checkbox"/> NG tube care & safety
					Giving my medicine <input type="checkbox"/> N/A <input type="checkbox"/> Measuring the dose <input type="checkbox"/> Knowing the schedule
					Putting me in my carseat
					(for boys) Taking care of my circumcision <input type="checkbox"/> needed <input type="checkbox"/> consented
					My family knows: (and they’re great at it!!!)
					How to tell when I’m sick enough to call my doctor
					My stress signals
					My bathroom habits
					How to tell when I’m healthy
					Using the bulb syringe
					My family has completed:
					Watching “Back to Sleep” video
					Watching Carseat Safety video
					Watching Infant CPR video
					<input type="checkbox"/> CPR/choking return demonstration <input type="checkbox"/> Registered for CPR class on:
					<input type="checkbox"/> Reviewed “We’re Going Home Discharge Guide” and/or Discharge Instructions
					Things I need before I go home:
					Doctor Ordered <input type="checkbox"/> Eye exam <input type="checkbox"/> Discharge Head Ultrasound
					Hearing Screening: Date done:
					Immunizations: <input type="checkbox"/> Hepatitis B vaccine <input type="checkbox"/> Synagis <input type="checkbox"/> Other:
					State Newborn Screen/Hct: Date done: <input type="checkbox"/> Bili <input type="checkbox"/> N/A
					Carseat trial (<37 wks gestation or on oxygen) (____ hrs)
					Referrals: <input type="checkbox"/> Social Work <input type="checkbox"/> Early Intervention <input type="checkbox"/> Other:
					Return Appointment: <input type="checkbox"/> Eyes <input type="checkbox"/> NICU <input type="checkbox"/> PCP <input type="checkbox"/> Other:
					<input type="checkbox"/> Prescriptions: <input type="checkbox"/> WIC; <input type="checkbox"/> Meds: <input type="checkbox"/> Vitamins/Fe; <input type="checkbox"/> Med sheets given
					<input type="checkbox"/> Home Health Nursing <input type="checkbox"/> Supplies
					<input type="checkbox"/> Bring Photo ID(ICU/Newborn) <input type="checkbox"/> Bring car seat and manual
					My pediatrician will be Dr. _____ at _____

Name/Signature/Title _____ Name/Signature/Title _____
 Name/Signature/Title _____ Name/Signature/Title _____
 Name/Signature/Title _____ Name/Signature/Title _____
 Name/Signature/Title _____ Name/Signature/Title _____
 Name/Signature/Title _____ Name/Signature/Title _____