SEPARATION SUMMARY

☐ from Acute Care
☐ from Long Term Care
☐ from Home Care

Date/Time: ______________________

OUTCOME/DISCHARGED TO: ☐ Improved, remains at home
☐ Home
☐ Special Care Home *(specify)* ______________________
☐ Other facility *(specify)* ______________________

MODE: ☐ NA ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Carried

BELONGINGS SENT WITH PATIENT: ☐ NA ☐ Yes ☐ No *(specify)*

WHO CAME FOR PATIENT: ☐ NA ______________________
(name and relationship):

PATIENT STATUS	INDEPENDENT	PARTIALLY DEPENDENT	DEPENDENT	N/A	COMMENTS
Hygiene function	☐	☐	☐	☐	
Bowel function	☐	☐	☐	☐	
Bladder function	☐	☐	☐	☐	
Food and fluid intake	☐	☐	☐	☐	
Ability to feed self	☐	☐	☐	☐	
Mobility	☐	☐	☐	☐	
Ability to use mobility devices	☐	☐	☐	☐	
Ability to use medications	☐	☐	☐	☐	
Ability to carry out treatments	☐	☐	☐	☐	
Overall ability to function	☐	☐	☐	☐	
	YES	**NO**	**N/A**		
Orientated (3 spheres)	☐	☐	☐		
Appropriate behaviour	☐	☐	☐		
Emotional status	☐	☐	☐		
Satisfied with care/services:	☐	☐			

If not, what would have made it better:

Understands how to obtain future assistance: ☐ Yes ☐ No

If yes, check all that apply: ☐ from home care ☐ for emergency care ☐ from physician

If no, explain:

☐ See Notes

ID: ______________________

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