



DISCHARGE INSTRUCTIONS

Patient Name:

Date:

Medical Record #:

DISCHARGE MEDICATIONS

Medication Name	Dose (Amount)	Route (How to take)	Frequency (How often)	Comments

- Make a follow-up appointment with your MD within one (1) to two (2) weeks or as needed.
- Call 911 in case of emergency such as chest pain, shortness of breath, signs and symptoms of stroke or bleeding, possible heart attack, pain not relieved by pain medication.
- Comply with current treatment.
- Comply with medications listed above, take as ordered
- Others: _____

Patient/Caregiver demonstrates/verbalizes understanding of discharge medication/instructions.

I acknowledge receipt of the above discharge medication/instructions.

Patient / Representative Signature

Staff Signature