List of medication including changes / additions (inc. liquid feed).
Do carers understand what these are for / how to administer / side effects?

.....

.....

.....

Any follow-up appointments / out patients / District Nurse referral?

.....

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.....

.....

Any other referrals required / additional funding required:
(Physio, swallowing assessment, Dietitian, Community Learning Disability Nurse, Transfer of Care Team, care management)

Referral to:	Named person responsible:
.....	.....
.....	.....
.....	.....
.....	.....

Any infections / pressure areas (MRSA, C.Difficile, other infections) who is managing these / have carers seen relevant policies / need training / resources?

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.....

How is the person getting home from hospital? (ambulance/own transport?)

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Please outline any action plan agreed / any other issues:

.....

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.....

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Agreed by the undersigned:

.....

Date: .....

SEND COPIES TO ALL PARTIES