|  |  |  |
| --- | --- | --- |
| **Patient Name:**  **Ward:** | | **DOB:** |
| **NHS No:**  **Swift Number if Council** | | **Date of Discharge:** |
| **GP:** | **Next of Kin: Please include name and telephone number** | |
| **Allergies:** | **DNAR (whilst in acute setting) YES/NO** | |
| **Changes in Medication since admission** |  | |
| **Has the person ben swabbed for COVID-19** |  | |
| **Confirmed Result of Test** |  | |
| **Name of Discharge Nurse** |  | |
| **Any altering care requirements since admission** |  | |

\*Further information attached e.g. body map/med chart/community/ DNAR/

**SIGNED**  **PRINT NAME**

**Designation Date**

**Contact number/email** [**services@telopeamsl.com**](mailto:services@telopeamsl.com) **– 01234 248969/07702383060**