



GRACE HOSPITAL

506 4

372940 103 065 440
ADMITTED 28/12/05 0628424
BOUCHARD, LIONEL MR
DR JOSHUA, J
22/01/24 81Y MB 277639
BOX 81
ELIE MB ROH OHO

NURSING DISCHARGE SUMMARY

Valuables returned	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> n/a
Home medications returned	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> n/a
Walking aides/Wheelchair etc.	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
Specify _____			
Prescriptions given	<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
Implant card given	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> n/a
Specify _____			
Copy of blood product record given	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> n/a

Discharged:

- Ambulatory
- Wheelchair
- Stretcher

Disclosed by Grace General Hospital
in compliance with
The Personal Health Information Act

To:

- Home with Self/Family Care
- Home with Community Agency Services
- Alternate Care Facility

daughter agreed to stay in pt. until necessary services in place.

Specify _____

Accompanied by daughter

Date: Jan 27/06 Discharge Time: 1115 Nurse Signature: H. Schwartz RN



GRACE HOSPITAL

300 BOOTH DRIVE
WINNIPEG, MB R3J 3M7

RECORD OF DISCLOSURE

PATIENT NAME <u>Bouchard, Lionel</u>	TO <u>Marlene Legare (daughter)</u>
HRN <u>572940</u> DATE <u>22/6/06</u>	ATTENTION _____
FROM <u>HEALTH RECORDS/MAROAH BORGIA</u> (Department/Unit/Name)	TELEPHONE NO. _____
TELEPHONE NO. <u>837-0164</u>	FAX NO. <u>1-604-467-5630</u>
FAX NO. <u>889-4795</u>	NO. PAGES SENT (incl. cover sheet) <u>3</u>

Mode of Disclosure Fax Mail Dr Slot Courier Sent With Patient

Is requesting doctor/facility currently treating the patient? Yes No

If no, please give reason for disclosure. _____

Patient Authorization Form Required: Yes Attached No

Information sent regarding treatment date(s) _____

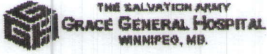
- | | |
|---|--|
| <input type="checkbox"/> Admission/Separation Record | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Anaesthetic Record | <input type="checkbox"/> Blood Gas Analysis |
| <input type="checkbox"/> Consultation Record(s) | <input type="checkbox"/> Biochemistry |
| <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> C & S |
| <input type="checkbox"/> CT Scan _____ | <input type="checkbox"/> Hematology |
| <input type="checkbox"/> Nuclear Medicine _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ultrasound _____ | |
| <input type="checkbox"/> X-ray _____ | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> OT Data Base/Progress Notes |
| <input type="checkbox"/> EKG Report(s) and Tracings | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Emergency Report Form | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> Emergency Triage Record | <input type="checkbox"/> Physio Req & Consult/Progress Notes |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Pulmonary Function Tests |
| <input type="checkbox"/> Neurological Record | <input type="checkbox"/> Recovery Room Record |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Spirometry |
| | <input type="checkbox"/> Stress Test |
| | <input type="checkbox"/> Transfer Sheet |

OTHER discharge instructions

Confidentiality Caution

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PART 1: DISCHARGE INSTRUCTIONS

Admission Date: Dec 28/06	Discharge Date: Jan. 27/06
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DIAGNOSIS(ES): Confusion

SUMMARY OF PERTINENT INVESTIGATIONS & TREATMENTS:

Bloodwork, blood cultures, urinalysis, CT scan (brain),
chest X Ray, EKG

DIET & ACTIVITY INSTRUCTIONS: Resume as prior to admission

FOLLOW-UP APPOINTMENT(S): REQUIRED: YES NO
Follow-up with your family doctor within one week
after discharge home

OTHER SERVICES/REFERRALS MADE: psychiatry, home care, social work,
physiotherapy.

See PART 3 for additional information: YES NO

HOME CARE: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Home Care Nurse to complete)
Special Equipment: _____
Services: 1. Nursing 1X week - medication
2. Am. drug, make breakfast, lunch, snack - med ensure
3. Bath assist 1X week
4. Supper heat & serve - med reminder @ bedtime
WRHA Case Coordinator: <u>Angela Woodman</u> Telephone No.: <u>735-3193</u>
Signature & Status: <u>E. Robinson RN</u> Date & Time: <u>Jan 29/06</u>

DISTRIBUTION:

Reviewed with and copy given to patient, family member. Date/Time: Jan 27/06 1100
 Patient's permission received to fax/mail to Dr. Jennifer Melstom @ Fax: _____
Elie Medical Clinic Date/Time: _____

FORM COMPLETED BY:

Signature & Status: <u>J Mackay RN</u>	Date & Time: <u>Jan. 27/06</u>
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**PART 2:
DISCHARGE MEDICATIONS**

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MAKES DAD
 DROWSY - FOR
 DEMENTIA
 NOT FILL
 ACCORDING
 TO NURSE

Medication (Name/Route)	Purpose	Instruction Sheet (✓)	Times to be Taken	Has Rx (✓) or Home Supply
1 Nitro patch 0.4 mg/hr	For the heart		put on first thing in the morning, Remove at bedtime	
2 Altace 10 mg pill	lowers blood pressure		At breakfast	
3 Terazosin	lowers blood pressure, helps urine blockage		At breakfast and bedtime	
4 Hydralazine 25mg	control BP		i first thing in AM i at lunch i at bedtime	
5 Olanzapine 2.5mg	For Dementia!		i breakfast + bedtime	
6 Lasix 40mg	diuretic		i breakfast	
7				
8				
9				
10				

To be taken as necessary:

1				
2				
3				
4				
5				

Completed by: *J Mackay* Status: MD RN CPN Pharmacy Date & Time: *Jan. 27/05 1050*