|  |  |
| --- | --- |
| **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** **– 01234 248969/07702383060**