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| --- | --- | --- |
| **Patient Details**  ***Please use a patient label*** | **Ward:** | |
| **Ward ext number:** | |
| **Staff Nurse:** | |
| **Consultant:** | |
| Part B Key Dates Log | | Date |
| 1. Multidisciplinary Team meeting held on | |  |
| **2 Date Section 5 (Fax 2) sent to Social Services *(to be completed by Discharge Team)*** | |  |
| **3 Agreed Discharge Date (*this date MUST be agreed by a Social Worker if your ward does not have an MDT meeting, please phone the Social Worker/Community Care Officer involved and agree a date.*** | |  |
| **Name of Social Worker/Community Care Officer who has agreed the discharge date**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |
| Part C Health Services Availability*(To be completed by ward staff)* | | Date |
| The following health services, required in the agreed discharge arrangements will be available on the confirmed date of discharge (date 4 above)  *Give brief description ( EG Community Nurse / Equipment / Continence products etc)* | |  |
| Part D Confirmation of Department of Adult Care Availability(To be completed by Social Worker/Community Care Officer) | | |
| *The following Social Services are required in the agreed care plan:* | | |
|  | | |
| *Give reasons why any social services will not be available:* | | |
|  | | |

Leaving hospital Leaflet given Yes No:

|  |  |
| --- | --- |
| **Signature of Social Worker/Community Care Officer** | **Print Name** |
|  |  |

|  |  |
| --- | --- |
| **Signature of Medical Professional** | **Print Name** |
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