Connecticut Department of Children and Families CONGREGATE CARE DISCHARGE SUMMARY

DCF-2271



4/18 (Rev) Last Name: DOB: Age: First Name: Gender: Allergies: Dates of Stay: LINK#: Medical Diagnosis: Behavioral Health Diagnosis: Past medical History

	First Name:	DOB:	Dates of Stay:	
Current Medications, /Drug/Dece/Doute/Time/	Last Dass/Target Cumptoms	If applicable please put	data of last CMCII consent	ohtainad
Current Medications: (Drug/Dose/Route/Time/	Last Dose/Target Symptoms).	ii applicable, please put	date of fast Civico consent	obtained:
Medication Changes: (Date/Drug//Dose/Routs	/Timo/Doscon Advorso Doscti	on No Effect)		
Wedication Changes. (Date/Drug//Dose/Nouts	Time/Neason, Adverse Neach	on, No Enecty		
Name of Primary Care Doctor or Specialist	PROCEDURES / SUF E-mail:	RGERY / HOSPITALIZAT	ION	Telephone:
Nume of Filmary Gare Boctor of Specialist	L maii.			тегерпопе.
Address:	City:		State:	Zip:
Date of last Visit / Reason / Outcome / .Follow-	up Appointment:			
Date of last Visit / Reason / Outcome / .Follow-	up Appointment:			
Date of last Visit / Reason / Outcome / .Follow-	up Appointment:		1	
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Date of last Visit / Reason / Outcome / .Follow-	up Appointment:			
Date of last Visit / Reason / Outcome / .Follow-	up Appointment:			
Other Specialists: (include name, address, date		ointments):		
		ointments):		

Last Name:		First	Name:		DOB:		Dates of Stay			
Name of Psychiatrist				E-mail:					Telepl	none:
,										
Address:			(City:			State:		Zip:	
Date of last Appointme	ent / Reason / Out	come / .Follo	ow-up Appointm	ent:					•	
Name of Dentist	Dentist			E-mail:				Telephone:		
Address:				City:			State:		Zip:	
Addiess.				City.		State.	Διρ.			
Date of last Dental Ex	am / Reason / Ou	tcome / .Foll	ow-up Appointm	nent:						
Name of Eye Doctor:			E-mail:				Telephone:			
Address:			City:			State:		Zip:		
Addicas.			Oity.		Oldio.		F.			
Date of last Vision Exam /.Follow-up Appointment:										
IMMUNIZATION:		AIMS			EKG			LABS		
☐ Current☐ Needs (Please lis	t holow):	Date: Results:			Date: Results			Date: Results		
☐ Needs (Flease iis	t below).	Results.			Results			Results	S.	
NUTRITION:			EXERCISE:		l			VE EQUIPM	ENT:	
Regular Unrestr Adjustment (Please list below): Recom			iricted nmended (Please list below): None Type of Equip		ie e of Equipme	ent Need	ed (Please let below):			
Height:	Weight:	BMI/I	BMI %	BP:		P:		R:		Pain Scale: (0-10)

Last Name:	First Name:	DOB:	Dates of Stay:	
Nursing Summary:				
	ARGE ACTIONS: Are the Doct		Yes No	50511115
Recent Physical: Immuniza	ation Record: EKG / L No Yes	AB Work:	AIMS: Yes No	FORM 465 Yes No
		VIDED	_ res _ no	
Yes No Medications (Including I Yes No Prescriptions (If 'Yes", µ		Yes No	Print Discharge Medication List	(If applicable)
Yes No Prescriptions (If 'Yes", p	olease listy:			
Was Education provided to parent or quardian	during this guarter? Voc.	No If "woo" place	aca pravida datalla	
Was Education provided to parent or guardian	during this quarter? Yes	No □. If "yes" plea	ase provide details:	
Comments:				
Name of RN Completing Assessment	Signature o	of RN		Date