**NICU Discharge Planning Worksheet for the Bedside Provider**

Baby’s Name in Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby’s Name after Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical record number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **During discharge meeting** | Date | Completedby (initials) |  |
| Discharge meeting held |  |  |
| Family given discharge packet |  |  |
| Family obtained a car seat |  |  |
| Family offered CPR class/video instruction |  |  |
| Family received “Shaken Baby” brochure |  |  |
| Pediatrician/PCP chosen |  |  |
| **No later than 1 week prior to anticipated discharge** | Date  | Completed by (initials) | Teach back date | Family declined | Comments |
| **Provide Discharge Teaching on:** |  |  |  |  |  |
| Feeding /Nutrition guidelines |  |  |  |  |  |
| Bowel and bladder patterns  |  |  |  |  |  |
| Bathing, skin care, cord care  |  |  |  |  |  |
| Temperature taking  |  |  |  |  |  |
| Circumcision care if needed |  |  |  |  |  |
| Protection from infection  |  |  |  |  |  |
| Medication administration |  |  |  |  |  |
| **Feeding** Infant transitioned to discharge feeding:(BM/Form. \_\_\_\_\_\_\_\_\_\_\_Kcal/oz \_\_\_\_\_) |  |  |  |  |  |
| Family received written feeding plan |  |  |  |  |  |
| Family received milk/formula recipe |  |  |  |  |  |
| Appropriate WIC forms given to family |  |  |  |  |  |
| **Medication/Medical Equipment**Family received discharge prescriptions Med: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose/Frequency: \_\_\_\_\_\_\_\_\_\_Med: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Frequency: \_\_\_\_\_\_\_\_\_\_Med: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Med: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Frequency: \_\_\_\_\_\_\_\_\_\_  |  |  |  |  |  |
| Requires home equipment: YES NO |  |  |  |  |  |
| If equipment required: Case management contacted |  |  |  |  |  |
|  Equipment (e.g., O2 Monitor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Company Contacted on 🡪Company Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Company Contact cell phone\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Date Company Provided education |  |  |  |  |  |
| **No later than 1-2 days prior to anticipated discharge** | Date  | Completedby (Initials) | Teach back date | Family declined  | Comments |
| **Reinforce Discharge Teaching on:** |  |  |  |  |  |
| Car seat instruction |  |  |  |  |  |
| When to call your baby’s doctor  |  |  |  |  |  |
| How to administer home medications |  |  |  |  |  |
| Hearing screening completePassed Referred L R |  |  |  |  |  |
| Discharge Newborn Screen sent |  |  |  |  |  |
| Car seat form complete |  |  |  |  |  |
| Family attended CPR class |  |  |  |  |  |
| Family offered CPR refresher video |  |  |  |  |  |
| Pediatrician appointment scheduledDr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time \_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Call to PCP (clinician-to-clinician handoff) |  |  |  |  |  |
| Attending completed discharge summary |  |  |  |  |  |
| Family given immunization book |  |  |  |  |  |
| Family received copies of discharge summary |  |  |  |  |  |
| **Day of discharge** | Date  | Completedby (Initials) |  |  |  |
| Bedside staff conducted the emotional readiness assessment below~ |  |  |  |  |  |
|  **Ask the primary caregiver to rate the following statements:** |  |  |  |
| I feel confident that my infant’s heart rate and breathing are safe | ☐ Not at all confident☐ Somewhat confident☐ Very confident |  |  |  |
| I feel confident that my infant is developing and growing now | ☐ Not at all confident☐ Somewhat confident☐ Very confident |  |  |  |
| I am ready for my infant to come home | ☐ Not at all ready☐ Somewhat ready☐ Very ready |  |  |  |

\*Any time family declines a comment is needed.

~ Document the answers provided by the primary caregiver the first time the assessment is conducted.