

Appendix 1. Sample family discharge checklist

## Going Home from the NICU

Baby's Name in hospital: \_\_\_\_\_

Baby's Name after discharge: \_\_\_\_\_

	Please check off items as they occur.	Additional Information	Parent Initials
In NICU	Discharge planning meeting		
	Pediatrician chosen Dr. _____ # _____		
	Baby added to insurance policy		
	CPR class complete		
	Handouts received and/or discussed with nurse <input type="checkbox"/> Safe Travels (car seat safety) <input type="checkbox"/> Safe Sleep Practices <input type="checkbox"/> Shaken Baby Syndrome <input type="checkbox"/> Carbon Monoxide and Smoke Detectors <input type="checkbox"/> Protecting Babies from Infection	<input type="checkbox"/> Temperature taking <input type="checkbox"/> When to Call the Pediatrician <input type="checkbox"/> Flu/Pertussis Vaccines for Families/Caregivers <input type="checkbox"/> Suction Bulb Use <input type="checkbox"/> Bathing Techniques <input type="checkbox"/> Tummy Time & Activities for 1 <sup>st</sup> Year	
Preparing for Home	Car seat brought to NICU and base installed in car		
	Supplies at home:		
	• Crib/bassinet (safety approved)		
	• Diapers, wipes, ointments		
	• Thermometer, suction bulb		
	• Feeding supplies	<input type="checkbox"/> Breast pump (if needed) <input type="checkbox"/> Nipple/Bottles <input type="checkbox"/> Formula (if needed)	
	• Circumcision care education	<input type="checkbox"/> N/A	
	Hearing screen results received *	* If referral needed, add to specialists.	
Written home feeding plan received			
Recipe for breast milk/formula received			
Car seat screen result received *	*If not passed, arrange for car bed.		
Going Home	Pediatrician visit date: __/__/__ Time: __:__	Visiting nurse date: __/__/__	
	Early Intervention arranged with _____		
	Specialists: _____ Name: _____ Date: __/__ Time: __:__ Name: _____ Date: __/__ Time: __:__		
	Med: _____ Dose/Frequency: _____ Med: _____ Dose/Frequency: _____ Med: _____ Dose/Frequency: _____	<input type="checkbox"/> Medications/Syringes obtained <input type="checkbox"/> Medication teaching complete	
	Received immunization booklet (blue book)		
	Parents Completed Discharge Readiness Questionnaire		

Appendix 2. Sample nurse discharge planning worksheet

## Nurse Discharge Planning Worksheet

Baby's Name in hospital: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Baby's Name after discharge: \_\_\_\_\_

During discharge meeting	Date	Completed by (RN initials)	Not Required	Family Declined	Comments
Discharge meeting held				<input type="checkbox"/>	
Family given discharge packet					
Family obtained a car seat					
Family offered CPR class				<input type="checkbox"/>	
Family received "Shaken Baby" brochure					
Pediatrician chosen					
<b>No later than 1 week prior to anticipated discharge</b>					
Early Intervention (EI) arranged			<input type="checkbox"/>	<input type="checkbox"/>	
Visiting Nurse (VNA) arranged Agency _____ Phone _____ Fax _____ Anticipated visit date __/__/__			<input type="checkbox"/>	<input type="checkbox"/>	
Infant data sent to Infant Follow Up Program (IFUP)			<input type="checkbox"/>	<input type="checkbox"/>	
Ophthalmology follow up Dr. _____ Date/Time: _____ Phone _____			<input type="checkbox"/>	<input type="checkbox"/>	
Other follow up appointments Specialty: _____ Dr. _____ Date/Time: _____ Phone _____  Specialty: _____ Dr. _____ Date/Time: _____ Phone _____  Specialty: _____ Dr. _____ Date/Time: _____ Phone _____			<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>		Other: _____
<b>Palivizumab</b> (Respiratory Syncytial Virus (RSV) season only ) Patient meets requirements? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Palivizumab parent information sheet given			<input type="checkbox"/>	<input type="checkbox"/>	
Palivizumab parent consent obtained			<input type="checkbox"/>	<input type="checkbox"/>	
Palivizumab injection given			<input type="checkbox"/>	<input type="checkbox"/>	
<b>Hepatitis B vaccine</b> Hepatitis B vaccine information statement given					

Hepatitis B vaccine consent obtained			<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B vaccine given			<input type="checkbox"/>	<input type="checkbox"/>	
<b>No later than 1 week prior to anticipated discharge</b>	<b>Date</b>	<b>Completed by (RN initials)</b>	<b>Not Required</b>	<b>Family Declined</b>	<b>Comments</b>
<b>Discharge Teaching</b>					
Feeding /Nutrition reviewed				<input type="checkbox"/>	
Bowel and bladder patterns reviewed				<input type="checkbox"/>	
Bulb syringe use reviewed				<input type="checkbox"/>	
Bathing, skin care, cord care reviewed				<input type="checkbox"/>	
Temperature taking reviewed				<input type="checkbox"/>	
Circumcision care			<input type="checkbox"/>	<input type="checkbox"/>	
Protection from infection reviewed				<input type="checkbox"/>	
<b>Feeding</b>			<input type="checkbox"/>		
Infant transitioned to discharge feeding: (BM/Form. _____ Kcal/oz _____)					
Family received written feeding plan			<input type="checkbox"/>		
Family received milk/formula recipe			<input type="checkbox"/>		
Appropriate WIC forms given to family			<input type="checkbox"/>	<input type="checkbox"/>	
<b>Medication/Medical Equipment</b>			<input type="checkbox"/>		
Family received discharge prescriptions					
Medication administration teaching completed Med: _____ Dose/Frequency: _____			<input type="checkbox"/>		
Med: _____ Dose/Frequency: _____					
Med: _____ Dose/Frequency: _____					
Requires home equipment? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If equipment required; case management contacted					
<b>Equipment (e.g. O<sub>2</sub> Monitor)</b>	<b>Company Contact Information</b>			<b>Date teaching completed</b>	
<b>No later than 1-2 days prior to anticipated discharge</b>	<b>Date</b>	<b>Completed by (RN initials)</b>	<b>Not Required</b>	<b>Family declined</b>	<b>Comments</b>
Pediatrician appointment scheduled Dr. _____ Date/Time _____ Phone _____					
Family given immunization book				<input type="checkbox"/>	

Family learned how to administer home medications			<input type="checkbox"/>	<input type="checkbox"/>	
Hearing screening complete Passed <input type="checkbox"/> Referred L <input type="checkbox"/> R <input type="checkbox"/>					
Car seat form complete			<input type="checkbox"/>		
Discharge Newborn Screen sent					
Family attended CPR class				<input type="checkbox"/>	
Family offered CPR refresher video				<input type="checkbox"/>	
When to call your baby's doctor reviewed			<input type="checkbox"/>	<input type="checkbox"/>	
Car seat instruction reviewed			<input type="checkbox"/>	<input type="checkbox"/>	
Attending completed discharge summary					If not, reason: _____
Family received a copy of discharge summary					If not, reason: _____
Completed Nurse Discharge Readiness Questionnaire					
RN's please provide quality improvement feedback/comments on this form and discharge process:					

## Appendix 3. Sample discharge summary format

### Neonatal Discharge Summary Template

1. Name of attending.
2. Service (“Neonatology”).
3. Patient's name as it appears in the hospital records.
4. Patient medical record number.
5. Date of birth.
6. Sex of patient.
7. Date of admission.
8. Date of discharge.
9. History:
  - a. The patient’s post-discharge name (*spell name*).
  - b. Include reason for admission, birth weight and gestational age.
  - c. Maternal history-including prenatal labs, pregnancy, labor, and birth history.
10. Physical examination at discharge including weight, head circumference, and length with percentiles at birth and discharge.
11. Summary of hospital course by systems (*concise*). Include pertinent lab results:
  - *Respiratory* - Initial impression. Surfactant given? Maximum level of support. Days on ventilation, CPAP, supplemental oxygen. If apnea, only report how patient was treated, when treatment ended and condition resolved.
  - *Cardiovascular* - Diagnoses/therapies in summary form. Echo/ECG results.
  - *Fluids, Electrolytes, Nutrition* - Brief feeding history. Include most recent weight, length and head circumference.
  - *GI* - Pertinent diagnoses and treatment. Maximum bilirubin and therapy used.
  - *Hematology* - Patient blood type, brief transfusion summary, most recent Hct.
  - *Infectious Disease* – Complete blood counts, cultures, colonization if appropriate, antibiotic courses.
  - *Neurology* - Describe ultrasound findings.
  - *Psychosocial*- Relevant observations of family function and psychosocial needs.
  - *Sensory*:
    - i. Audiology: “Hearing screening was performed with automated auditory brainstem responses, revealing\_\_\_\_\_ [*include results*].” [*If didn’t pass, indicate date/place of follow-up test. If not done, recommend test prior to discharge.*]
    - ii. Ophthalmology:
      - Indicate if infant did not meet criteria for eye exam
      - Indicate if infant has not yet been examined but does require

exam

- If ROP was ever detected, include maximum stage of ROP and date of that exam
- For all, include date and results of last exam
- If not mature, state plans for follow-up including date and time of scheduled appointment
- If mature, state time frame for routine follow-up

12. Condition at discharge including prognosis if guarded or grim. (*e.g.* "stable")

13. Discharge disposition (*e.g.* "home," "Level II," "Level III," "chronic care")

14. Name of primary pediatrician (*spell name*). Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

15. Care/recommendations.

- a. Feeds at discharge including volume, calories, and frequency.
- b. Medications including each medication's dose (concentration if volume), route, frequency.
- c. Medical equipment and supply needs
- d. Car seat position screening (*if < 37 weeks gestation*).
- e. State newborn screening status including dates and known results.
- f. Immunizations received including dates.
- g. Follow-up appointments scheduled/recommended.
- h. Discharge diagnoses list.