Connecticut Department of Children and Families
CONGREGATE CARE DISCHARGE SUMMARY
DCF-2271
4/18 (Rev)

Last Name:	First Name:	DOB:	Age:	Gender: Select One or enter your own
LINK#:	Allergies:		Dates of Stay:	

Medical Diagnosis:

Behavioral Health Diagnosis:

Past medical History

Last Name:	First Name:	DOB:	Dates of Stay:

Current Medications: (Drug/Dose/Route/Time/Last Dose/Target Symptoms). If applicable, please put date of last CMCU consent obtained:

Medication Changes: (Date/Drug//Dose/Routs/Time/Reason, Adverse Reaction, No Effect)

PROCEDURES / SURGERY / HOSPITALIZATION

Name of Primary Care Doctor or Specialist	E-mail:		Telephone:
Address:	City:	State: Connecticut	Zip:

Date of last Visit / Reason / Outcome / .Follow-up Appointment:

Other Specialists: (include name, address, date of last visit and follow-up appointments):

Last Name:	First Name:	DOB:	Dates of Stay:

Name of Psychiatrist	E-mail:		Telephone:
Address:	City:	State: Connecticut	Zip:

Date of last Appointment / Reason / Outcome / .Follow-up Appointment:

Name of Dentist	E-mail:		Telephone:
Address:	City:	State: Connecticut	Zip:

Date of last Dental Exam / Reason / Outcome / .Follow-up Appointment:

Name of Eye Doctor:	E-mail:		Telephone:
Address:	City:	State: Connecticut	Zip:

Date of last Vision Exam /.Follow-up Appointment:

IMMUNIZATION: ☐ Current ☐ Needs (Please list below):	AIMS Date: Results:	EKG Date: Results	LABS Date: Results:

NUTRITION: ☐ Regular ☐ Adjustment (Please list below):	EXERCISE: ☐ Unrestricted ☐ Recommended (Please list below):	ADAPTIVE EQUIPMENT: ☐ None ☐ Type of Equipment Needed (Please let below):

Height:	Weight:	BMI/BMI %	BP:	P:	R:	Pain Scale: (0-10)

Last Name:	First Name:	DOB:	Dates of Stay:

Nursing Summary:

DISCHARGE ACTIONS: Are the Documents Attached? ☐ Yes ☐ No

Recent Physical:	Immunization Record:	EKG / LAB Work:	AIMS:	FORM 465
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PROVIDED

☐ Yes ☐ No Medications (Including Inhalers and Epi Pens)

☐ Yes ☐ No Print Discharge Medication List (If applicable)

☐ Yes ☐ No Prescriptions (If 'Yes", please list):

Was Education provided to parent or guardian during this quarter? Yes ☐ No ☐. If "yes" please provide details:

Comments:

Name of RN Completing Assessment	Signature of RN	Date