

Date: [Insert Date]

To: Administrator/Director of Care

Facility Name: [Insert Memory Care Unit Name]

Address: [Insert Facility Address]

RE: Discharge Summary for [Patient Full Name]

Date of Birth: [Insert DOB]

Date of Admission: [Insert Date]

Date of Discharge: [Insert Date]

Diagnosis:

- Primary Diagnosis: [e.g., Alzheimer's Disease / Vascular Dementia]
- Secondary Diagnoses: [e.g., Hypertension, Type 2 Diabetes]
- Cognitive Status: [e.g., MMSE/MoCA Score]

Clinical Summary:

[Briefly describe the clinical course, stabilization of symptoms, or changes in cognitive status during the clinic stay.]

Medication List:

[Insert list of medications, dosages, and frequencies. Highlight any new changes or discontinued drugs.]

Behavioral and Safety Plan:

- Wandering Risk: [Low/Medium/High]
- Aggression/Agitation Management: [Specify triggers and interventions]
- Fall Risk Status: [Specify precautions]
- Assistance required for Activities of Daily Living (ADLs): [Specify level of care]

Dietary and Allergy Information:

Dietary Needs: [e.g., Pureed, Low Sodium]

Allergies: [List all allergies or state "No Known Drug Allergies"]

Follow-Up Appointments:

[List upcoming specialist or GP appointments with dates and times.]

Contact Information:

For questions regarding this discharge, please contact [Clinic Name] at [Phone Number].

Sincerely,

[Signature]

[Printed Name and Title]

[Clinic Name]