



Overview of the Discharge Planning Process

After referring for discharge, you should have total peace of mind that all your client's needs are being assessed and addressed because to ensure a comprehensive discharge, the Rehabilitation Professional should conduct all of the following tasks.

<i>Receipt of Referral</i>	<ul style="list-style-type: none"> • Receive referral and contact hospital and client (or family if appropriate.)
<i>Hospital Visit & Professional Consultation</i>	<ul style="list-style-type: none"> • Visit hospital prior to discharge day to proactively and comprehensively plan the discharge by obtaining signed waivers to speak with treating specialists (Physicians, Occupational Therapists, Physiotherapists, Social Workers, Speech Language Pathologists, Discharge Planner) • Obtain all relevant medical documentation.
<i>Occupational Therapy Home Visit</i>	<ul style="list-style-type: none"> • Visit the client's home by an Occupational Therapist prior to discharge (if possible) to address accessibility and safety issues and determine appropriate equipment needs. • Some aspects can usually be handled via telephone. (For example, in cases where there are not a lot of medical / mobility concerns a hospital visit may not be necessary and arrangements can be made on the telephone).
<i>Determine the need for Attendant Care</i>	<ul style="list-style-type: none"> • Based on the hospital and home visit the client's attendant care needs are assessed for personal care issues. • Attendant Care Assessment is ideally performed once the client has returned home. However, there are some instances when this assessment must be completed in advance of discharge from hospital and arrangements made for attendant care services to be provided in the client's discharge location.
<i>Ongoing Communication with Adjuster</i>	<ul style="list-style-type: none"> • Contact Adjuster to discuss file status and obtain approval for initial recommendations and obtain authorization for the implementation of urgent recommendations.
<i>Coordination of Community Services</i>	<ul style="list-style-type: none"> • Determine services available to the client after discharge from organizations such as CCAC (Community Care Access Centre). • Implement referrals to community-based services, treatment providers and physicians.
<i>Transportation</i>	<ul style="list-style-type: none"> • Arrange transportation home if needed and for future medical treatment/follow-up if required.
<i>Follow-up Visit</i>	<ul style="list-style-type: none"> • Immediately after discharge, an Occupational Therapist should visit the client at home to ensure that all safety, accessibility and equipment issues have been addressed.
<i>Follow-up Communication with Adjuster</i>	<ul style="list-style-type: none"> • Keep Adjuster informed throughout the process, as well as regarding final arrangements after discharge, such as transportation to medical follow-up appointments (as applicable) and information about any treating Healthcare Professionals involved in the client's care post discharge.