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**PATIENT-ORIENTED DISCHARGE SUMMARY PESU**

**PATIENT’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISCHARGE DATE (Day, Month, Year)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I came into PESU because** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am being discharged/transferred to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_via\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | MEDICATIONS I NEED TO TAKE(new or changed) |
|  My medications have NOT changed New or changed medications listed below |
| **NAME** | **DOSE** | **TIME** | **WHAT FOR** | **INSTRUCTIONS** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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| --- |
| FOLLOW-UP |
| **TORONTO WESTERN HOSPITAL** |  **OTHER (EXTERNAL)** |
| * Urgent Care Clinic
* Crisis Clinician
* Community Mental Health
* Family Health Team
* IMPACT
 | * Family Physician
* Psychiatrist
* Counsellor
* Other \_\_\_\_\_\_\_\_\_
 |

|  |  |
| --- | --- |
|  | APPOINTMENTS I HAVE TO GO TO |
| **WHO** | **WHERE** | **WHEN** | **BOOKED** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | RESOURCES | MY CRISIS PLAN |
| Distress Line | 416 408 4357 |  |
| Gerstein Crisis Centre | 416 929 5200 |  |
| Food Bank | 416 203 0050 |  |
| Detox Central Access | 1 866 366 9513 |  |
| Shelters, Central Line | 416 338 4766 |  |
| Big White Wall | bigwhitewall.ca |  |
|  |  |  |
|  |  |  |

**Please go to the nearest Emergency Department if you are feeling unwell or suicidal.**

 I have all my belongings and valuables with me.

If you have any concerns during your visit in PESU, please contact the Manager, Mohammed Oruvampurath (416 603 3470) and/or Patient Relations (416 340 4907)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient signature Staff signature