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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** |
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| --- | --- | --- | --- |
|  | 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