Rapid Patient Discharge Assessment

Patient Care Unit Profile

Hospital Name: _____ Date:_____

Unit Name: _____

(Note: on following forms, please be consistent and fill in the unit name as you listed here)

Name of person completing form: _____

Title (e.g. Nurse Manager):_____

Unit Type (Choose most specific type):

(_) Medical	(_) Neurology Only	Critical Care
(_) Surgical	(_) Chemical Detox	(_) Medical CCU
(_) Pediatric	(_) Physical Rehab	(_) Surgical CCU
(_) Cardiology Only	(_) Hospice or Palliative Care	(_) Cardiac CCU
(_) Psychiatric	(_) Step Down (Any type)	(_) NICU
(_) Oncology Only	(_) Other: _____	(_) _____

CENSUS

- **Total Number of Patients <u>currently</u> on the unit: _____**
- **Number of identified <u>confirmed discharges</u> (except critical care): _____**
- **Number of identified <u>potential discharges</u> (except critical care): _____**

RETURN COMPLETED FORM TO BED MANAGEMENT COMMITTEE LEADER