Guillain-Barre syndrome recovery: discharge

Original independent practice. Assume that today's date is 5 November 2026. Mr Ahmed Slingerland is being discharged home this afternoon. You are a registered nurse in the inpatient rehabilitation unit. Using the case notes, write a discharge letter to Ms Gaby Pastoors, Community Rehabilitation Nurse, Home Transition Service, 18 Station Road, NSW 2000, Australia. Request a home assessment and continued rehabilitation support for Mr Slingerland, including safe continuity of assistance after discharge. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mr Ahmed Slingerland	☐	☐	☐
2. DOB: 14/03/1968 (58 yrs)	☐	☐	☐
3. Home: 7 Park Road, NSW 2000, Australia	☐	☐	☐
4. Admitted 23/09/26; discharge home 05/11/26	☐	☐	☐
Social background			
5. Lives with wife; accessible ground-floor flat	☐	☐	☐
6. Taxi driver; currently off work	☐	☐	☐
7. Enjoys collecting old postcards	☐	☐	☐
8. Wife privately complained about daughter's marriage	☐	☐	☐
Medical history and admission			
9. Appendicectomy in childhood; no ongoing problems	☐	☐	☐
10. Guillain-Barré syndrome diagnosed 24/09 after progressive limb weakness	☐	☐	☐
11. IV immunoglobulin completed during acute admission	☐	☐	☐
12. Did not require ventilation	☐	☐	☐
13. Transferred to rehabilitation unit 12/10	☐	☐	☐
Current assessment			
14. Residual bilateral leg weakness; fatigues easily	☐	☐	☐
15. No current breathing or swallowing difficulties	☐	☐	☐
16. 05/11, patient reports: transfers independently; help no longer needed	☐	☐	☐
17. 04/11, physiotherapist observed: bed→chair required 1-person physical assistance + frame; knees buckled with fatigue	☐	☐	☐
Current assessment			
18. Independent feeding/grooming; seated rest breaks needed	☐	☐	☐
Treatment and progress			
19. Current team plan: every transfer with 1 trained adult's physical assistance + frame; no unaided transfers pending reassessment	☐	☐	☐
20. Wife demonstrated prescribed assistance safely; continuously available through 06/11 nurse visit; returns to work afterwards	☐	☐	☐
21. Frame, raised chair and shower chair installed at home	☐	☐	☐
22. OT home assessment completed 03/11; equipment checked	☐	☐	☐
23. Individual pacing programme supplied: alternate activities with seated rest	☐	☐	☐
24. Separate home-care worker arranged for daily shower assistance; no cover for other transfers	☐	☐	☐
25. Complained that ward meals were repetitive	☐	☐	☐
Discharge plan			
26. 06/11 Home Transition Service visit: observe transfers; liaise with physiotherapy before ↓ support. Trained carer rota confirmed: every transfer from visit's end until physiotherapy confirms independent transfers safe; nurse to check handover	☐	☐	☐
27. Patient accepts assistance pending review despite reporting independence	☐	☐	☐
28. Community physiotherapy home visit booked 09/11	☐	☐	☐
29. Neurology outpatient review booked 03/12	☐	☐	☐
30. Team safety advice: new/worsening weakness → contact neurology immediately; breathing difficulty → ambulance (000)	☐	☐	☐