SEQUOIA
Integrative Medical Services

Date:_____

Patient : _____ DOB:_____

Facility: _____ Facility Contact: _____

Phone: _____ Fax: _____

Anticipated Discharge Date: _____

Discharge Destination:

- ☐ Home alone
- ☐ Home with family/friends
- ☐ Assisted living facility
- ☐ Nursing Home/LTC
- ☐ Other: _____

Transportation to Discharge Destination: Is transportation set up? ☐ Yes ☐ No

If yes, please specify: _____

Skilled Needs upon Discharge: ☐ Yes ☐ No

- ☐ Skilled Nursing (Wound care, Cath care, etc.)
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Other: _____

Durable Medical Equipment (DME) evaluation/Needs? ☐ Yes ☐ No

If yes, please specify: _____

Health care proxy/Durable Power of Attorney? ☐ Yes ☐ No

If yes, please specify: _____

Medication Review and Reconciliation completed? ☐ Yes ☐ No

PLEASE ATTACH DISCHARGE MEDICATION LIST

Please note any other needs: _____

_____

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