

Date: _____

Patient Name: _____ 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:

- None
- 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: _____

Healthcare 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: _____
