SEQUOIA
Integrative Medical Services

DISCHARGE PLANNING FORM

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: _____

_____

_____

Central WI
Fax: (920) 543-5288
Triage: (920) 422-7074

Western WI
Fax: (715) 520-5288
Triage: (920) 372-4268