Patient Contact Information

Patient name: _____ **DOB**: ____ / ____ / _____

Phone Number (home): _____ **Phone Number (work)**: _____

Address: _____ **Apt.**: _____ **City**: _____ **State**: _____ **Zip**: _____

Emergency Contact: _____ **Relationship to Patient**: _____

Emergency Contact Phone Number: _____

Discharge Information

Discharging Facility: _____

Discharging Facility Phone Number: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Patient Medical Record #: _____

Date of Admission: ____ / ____ / _____ **Discharge Date**: ____ / ____ / _____

Discharged to: ☐ Home (if not the same address as above, fill in address below)

☐ Rehabilitation Center ☐ Hospice Care ☐ Long-Term Care Facility ☐ Other Facility

Name of Facility: _____ **Phone Number**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Patient Follow-Up Appointment

Patient Follow-Up Appointment Date: ____ / ____ / _____

Physician Assuming Care: _____ **Phone Number**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Individual Filling out Discharge Form (print): _____ **Date**: ____ / ____ / _____

Responsible Physician at Discharging Facility: _____ **License #**: _____

Signature of Responsible Physician at Discharging Facility: _____

Phone Number: _____