

Hospital Discharge Form

Basic Information

Complete this form for all hospital discharges. Refer to Hospital Discharge Summary Form Instructions for information on how to complete this form.

Patient's Name:

Patient's I.D. #:

Phone Number:

Attending Physician:

Facility Name:

Date Services should end:

Elements that need to be put in place prior to discharge (verify that the following information is documented in the record, if applicable)

- ☐ Physician note reflecting readiness for discharge
- ☐ Discharge plan discussed with member/family
- ☐ Discharge plan discussed with attending provider
- ☒ Description of discharge plan in place
- ☐ Therapy notes (if applicable)

Medical Information

Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. (Use full sentences, plain language and no abbreviations)

a. You were admitted to (see facility above) on the following date

b. At admission you presented with the following symptoms

Medical Information Continues...

c. You were diagnosed with

d. You were treated with

e. Your tests were (include results)

Medical Information Continues...

f. You were evaluated by

g. You are now (list current treatment plan and/or state the medical issue is resolved)

h. Your provider feels that your condition has improved and that the care you need now could safely be provided in/at

i. Your discharge plan and follow-up care includes

Other Information

Printed name of person completing the form:

Phone Number:

Signature of person completing the form

Person completing the form

Name:

Date: