Facility Name

Address and Phone

DISCHARGE PLANNING AND CARE COORDINATION PATIENT REPORT

** Indicates High Risk Areas of Concern*

Name _____ **DOB** _____ **Phone #** _____

ACO Patient: ☐ **Yes** ☐ **No**

BPCI Patient: ☐ **Yes** ☐ **No**

Is Patient Being Followed up with by the Population Health Team(PHT): ☐ **Yes** ☐ **No**

Facility Physician Dr. _____ **Phone #** _____

Primary Care Physician _____ **Phone #** _____

Admitted From _____

Admission Date _____ **Discharge Date / Time** _____

Discharging to: ☐ Home ☐ Another LTC Facility ☐ ALF ☐ IRF ☐ LTCM
☐ Other _____

Address Phone # _____ _____

Primary Contact _____ **Relationship to Patient** _____

Cell Phone # _____ **Home Phone#** _____

***Support System** _____

Discharge Transportation Being Provided By _____ **Phone #** _____

Transportation at Home: ☐Available *☐Not Available (**Describe How Being Rectified)**

_____

Primary Insurance _____

Policy # _____ **Group #** _____

If Medicare, How Many Days Used _____

Secondary Insurance _____

Policy # _____ **Group #** _____

If Medicaid Pending:

Name of Caseworker _____ **Phone #** _____

Did Patient Participate in Decision? ☐ Yes ☐ No

Did Representative Participate in Decision? ☐ **Yes** ☐ **No**

Attitude About Discharge/Comments:

_____

SOCIAL SERVICES

REFERRALS

Per your request, a referral has been made to:

☐ _____ for an evaluation for skilled home care services. They have indicated a start date of _____. If you need to contact them, the main # is _____.

☐ _____ for an evaluation for Personal Certified Assistant services (PCA). Your PCA services should start _____. If you need to contact them, the main # is _____.

☐ _____ for private duty home care. If you need to contact them, the main # is _____

☐ _____ for Hospice. If you need to contact them, the main # is _____

☐ _____ for Outpatient Therapy. They have indicated a start date of _____. If you need to contact them the main # is _____.

☐ _____ for grocery delivery service. If you need to contact them, the main # is _____

***PSYCHOSOCIAL CONCERNS:** No ☐ Yes ☐ .

OTHER/NOTES In case of an emergency, dial 911.

Patient was assisted in choosing appropriate post-acute care providers by being given available data found on Medicare.gov ☐ Yes ☐ No (Explain}:

Typed or Printed Name of Person Completing Section | Signature of Person Completing Section | Date

ACTIVITIES

SUMMARY OF CUSTOMARY ROUTINE AND ACTIVITY PURSUITS (Include any interest in post d/c activities and what, if any, assistance was provided to facilitate):

Typed or Printed Name of Person Completing Section | Signature of Person Completing Section | Date