



Skilled Discharge Planning Form

Instructions: Discharge Planning begins on the 1st day of patient/resident admission. Please complete and fax this form with each update thru discharge. If no change, resubmit with a signature and date at the bottom of the second page and state "no change."

Patient Name: _____ **ID#:** _____ **DOB:** _____

Anticipated DC Date: _____

Facility DC Planner: _____ **Phone #:** _____

Prior Level of Function: _____

<p>Discharge to: (Check all that apply)</p> <p>Name of Facility: _____</p> <p>Discharge Location Phone #: _____</p>	<p><input type="checkbox"/> Home: ___Multilevel ___2 Story___Ranch ___Steps to Enter___Bed/Bath Level ___Steps within Home</p> <p><input type="checkbox"/> Outpatient <input type="checkbox"/> HHA _____ Circle: PT OT ST RN Other</p> <p><input type="checkbox"/> Long Term Care <input type="checkbox"/> Assisted Living</p> <p><input type="checkbox"/> Rehab Center <input type="checkbox"/> LTAC</p> <p><input type="checkbox"/> Acute Care <input type="checkbox"/> Hospice</p> <p><input type="checkbox"/> Group Home <input type="checkbox"/> Other</p>
<p>Caregiver Relationship:</p> <p>Name of Caregiver: _____</p> <p>Address: _____</p> <p>City/State: _____ Zip: _____</p> <p>Phone: _____</p> <p>Availability for physical assist: _____</p>	<p><input type="checkbox"/> Lives Alone <input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Significant Other <input type="checkbox"/> Guardian</p> <p><input type="checkbox"/> Daughter-Son</p> <p><input type="checkbox"/> Sibling <input type="checkbox"/> Other Family</p> <p><input type="checkbox"/> Friend <input type="checkbox"/> Neighbor</p> <p>Additional Caregiver: _____</p> <p>Address: _____</p> <p>City/State: _____ Zip: _____</p> <p>Phone: _____</p> <p>Availability for physical assist: _____</p>
<p>Family Support Contacts:</p> <p>Are there any caregiver issues that we should be aware of to better assist member?</p>	<p>Name: _____</p> <p>Relationship: _____</p> <p>Phone: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Describe: _____</p>

<p>Are there any transportation needs?</p> <p>Type of Transportation Needed:</p> <p>Who will provide Transportation:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Describe:</p> <p><input type="checkbox"/> Ambulance <input type="checkbox"/> Ambulette</p> <p><input type="checkbox"/> Automobile</p> <p>_____</p>
<p>DME Required:</p> <p>Please Use: _____</p> <p>Phone #: _____</p>	<p><input type="checkbox"/> Wheel Chair <input type="checkbox"/> Walker (type) _____</p> <p><input type="checkbox"/> Cane <input type="checkbox"/> Reachers</p> <p><input type="checkbox"/> Sock Aid <input type="checkbox"/> Ramp</p> <p><input type="checkbox"/> Elevated Toilet Seat <input type="checkbox"/> Safety Rails</p> <p><input type="checkbox"/> Other <input type="checkbox"/> None Required</p>
<p>Members Current Activity Level/ Mental Status:</p> <p>Depression Screen/Mini Mental?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Independent <input type="checkbox"/> Immobile</p> <p><input type="checkbox"/> Minimal Assist <input type="checkbox"/> Full Assist</p> <p><input type="checkbox"/> Alert <input type="checkbox"/> Oriented</p> <p><input type="checkbox"/> Cooperative <input type="checkbox"/> Confused</p> <p><input type="checkbox"/> Agitated</p> <p>Describe Needs:</p>
<p>Is patient Safe/Competent to return home?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No:</p> <p>DPOA: _____</p> <p>DPOA/HC: _____</p> <p>Name: _____</p> <p>Phone #: _____</p>
<p>Financial Planning:</p>	<p><input type="checkbox"/> Medicaid <input type="checkbox"/> Disability Application</p> <p><input type="checkbox"/> Private Pay <input type="checkbox"/> Secondary Insurance</p> <p><input type="checkbox"/> Adult Protective Services</p> <p><input type="checkbox"/> Other</p>

Follow Up Doctor Appointment:
Name _____ **Date** _____

Comments: _____

Signatures: _____ **Date:** _____

Patient Name: _____

Date: _____