CLINICAL DISCHARGE

Clinical Discharge Details

Clinical Discharge

Discharge Information

Discharge Date:*

__/__/____

Discharging from: (Provider/Facility)*

What level of care is the participant discharging from?*

Member Information

Is the member discharging to a place other than home?**
○ Yes ○ No

Participant contact phone upon discharge:*

___-___-____

Participant contact address upon discharge:

Does member have a legal guardian?**
○ Yes ○ No

Discharge Disposition:*

Clinical disposition at time of discharge:*

Follow-Up Appointment Information

Has a follow-up appointment been scheduled?**
○ Yes ○ No

Data Capture Required:
◉ Yes