Hospital Discharge Form

First Name ______________________

Last Name ______________________

DOB ______________________

Phone # ______________________ Email ______________________

Follow Up Appointment

Date: ______________________ Time: ______________________

Location: ______________________

- ☐ Is the patient being discharged with required medication?
- ☐ Does the patient have any language barriers?

Does the patient have any health conditions that would:

- ☐ Prevent them from completing activities of daily living such as inability to self-transfer from wheelchair to bed or toilet?
- ☐ Prevent them from climbing on a top bunk?
- ☐ Prevent them from leaving the shelter daily such as mobility issues?
- ☐ Necessitate accommodations for durable medical equipment such as plug