Discharge Planning and Referral Form

LeadingAge®

PATHWAY HEALTH
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Discharge Planning and Referral Form

Resident Name	**Medical Record #**
Primary Contact Person	**Relationship**
Proposed Discharge Date	**Discharge Location**

Communication with Local Contact Agency

Date of Initial Contact	**Local Contact Agency Assigned**
Has coordination with the Local Contact Agency been assigned? **Yes / No - Explain**	**When did the initial conversation occur with the Local Contact Agency?** **Date:** **Time:** **Name of person contacted:** **Title of person contacted:**

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Housing

What type of residence has the resident indicated that they wish to be discharged, i.e., another nursing facility, assisted living facility, private home, etc.?	**Anticipated New Address:**
Have any barriers and/ or challenges been identified?	**Plan to resolve barriers:**

Need for Referrals

Is the resident enrolled in a managed care plan?	**Name of managed care plan:**
Has the resident been referred for Hospice services?	**Name of Hospice:** **Date of Referral:**
Has the resident been referred for Home Health services?	**Name of Home Health:** **Date of Referral:**
Has the resident been referred for other services?	**Name of Other Services:** **Date of Referral:** **Name of Other Services:** **Date of Referral:**

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Durable Medical Equipment

Does the resident require any durable medical equipment, i.e., hospital bed, wheelchair, walker, etc.? If so, what does the resident require? (List all that apply)	**Has the equipment been ordered?** **Date:** **Time:** **Name of vendor contacted:**

Medical Transportation

Type of transportation used to transition into the community:	**Name of transportation company:** **Date set up:** **Name of person contacted:**	**Name of family member transporting:** **Phone Number:**

Therapy

Does the resident require therapy?	**Therapy needs requested:** **Date set up:** **Name of Provider:** **Phone Number:**	**Date Completed:**

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Appointments

<table>
<tr><td rowspan="7">Have any medical or special appointments been pre-arranged for the resident upon discharge?</td><td colspan="3">List of Pre-Arranged Appointments</td><td rowspan="7">Special Instructions:</td></tr>
<tr><td>Appointment</td><td>Date Set Up</td><td>Name of Provider</td></tr>
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<tr><td>Name and phone number of who to call in case of an emergency :</td><td colspan="3">Primary Physician phone number:</td><td>Primary Clinic phone number:</td></tr>
</table>

Date Discharge Completed:_____

Signature of Facility Representative:_____ **Date Signed**:_____