

Discharge Consultation Documentation

Please Fax to 877-398-9466

Member Name: _____ DOB: _____

Member ID #: _____ Parent/Guardian: _____

Address: _____

Phone: _____ Best time to reach member/parent/guardian: _____

Emergency and/or Additional Point of Contact: _____ Phone: _____

Would patient benefit from complex Case Management by Magnolia Health? Y ___ N ___

Follow up Appointments (Provider, Provider Type, When Where, Contact Information):

1. Primary Care Provider:

All appointments following a discharge are required to be set within thirty calendar days with a provider. Any appointments outside this time frame will need to be reported to Magnolia Health to allow for assistance with the appropriate level of follow-up.

Discharge Diagnosis:

I. _____ IV. _____

II. _____ V. _____

III. _____

List Discharge Medications (Name, Dosage, Instructions):

1.

Discharge Consultation Documentation, cont'd

Discharge Disposition:

Home _____ Home with HH _____ IP Rehab _____ SNF _____ Hospice _____
Other _____

Member Lives:

Alone _____ With Spouse or SO _____ With Family _____ Other _____

Functional Assessment:

Independent _____ Parital Dependence* _____ Total Dependence _____
**Partial Dependence: Needed help with bating, toileting, food prep, medications, other*

Cognitive Assessment:

Able to make own decisions _____ Needs assistance making decisions _____ Unable to make decisions _____

D/C Instructions:

1.

D/C Needs:

DME _____ HH _____ Wound Care _____ Other outpatient services (PT/OT/ST) _____

Company providing service: _____

Signature of Facility Staff

Date of Admission/Discharge

Time of Discharge