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