

## **SNF/ Rehab Discharge Documentation**

DME PROVIDER:  SERVICES (wheelchair, walker, bedside commode):  CONTACT INFORMATION:  CONTACT PERSON:  OUTPATIENT THERAPY LOCATION:  PHONE NUMBER:  How will member leave from facility? (Please circle) Private vehicle/ Ambulance (give reason for transport)  Where will member go after d/c from facility? With whom: (please circle) Alone/ Family/ ALF Name:		DATE:
FACILITY: LEVEL OF CARE AT D/C:  DISCHARGE DATE:  DISCHARGE SERVICES AND PROVIDER CONTACT INFORMATION  HOME CARE PROVIDER:  SERVICES (SN, PT, OT, ST):  CONTACT NUMBER:  CONTACT PERSON:  DME PROVIDER:  SERVICES (wheelchair, walker, bedside commode):  CONTACT INFORMATION:  CONTACT INFORMATION:  CONTACT PERSON:  OUTPATIENT THERAPY LOCATION:  PHONE NUMBER:  How will member leave from facility? (Please circle) Private vehicle/ Ambulance (give reason for transport)  Where will member go after d/c from facility? With whom: (please circle) Alone/ Family/ ALF Name:  Address: Phone:  NOMNC Issued: Yes □ No □ NOMNC Returned: Yes □ No □  Follow-up Appts.:	MEMBER:	ID:
DISCHARGE SERVICES AND PROVIDER CONTACT INFORMATION HOME CARE PROVIDER:  SERVICES (SN, PT, OT, ST):  CONTACT NUMBER:  CONTACT PERSON:  DME PROVIDER:  SERVICES (wheelchair, walker, bedside commode):  CONTACT INFORMATION:  CONTACT INFORMATION:  CONTACT PERSON:  OUTPATIENT THERAPY LOCATION:  PHONE NUMBER:  How will member leave from facility? (Please circle) Private vehicle/ Ambulance (give reason for transport)  Where will member go after d/c from facility? With whom: (please circle) Alone/ Family/ ALF Name:  Address:  Phone:  NOMNC Issued: Yes   No   NOMNC Returned: Yes   No    Follow-up Appts.:		
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Name:	for transport)	
Follow-up Appts.:	Name:	
Follow-up Appts.:		
		NOMNC Returned: Yes $\square$ No $\square$
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