VIVA HEALTH

SNF/ Rehab Discharge Documentation

DATE: _____

MEMBER: _____ ID: _____
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 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.: _____
Discharge Medications (Complete or Attach):

_____
_____
_____
_____
_____