Discharge Communication Form

Complete and fax to 504-849-6979.

Date:_________________

Form must be submitted for Peoples Health plan members within 3 days of discharge.
May be submitted prior to discharge.

Member Name:_______________________________________

Member DOB:____________________ Member Plan ID Number:____________________

Facility Name:____

Facility Contact: _______________________________________ Facility Phone Number:________________________

Discharge Date:___________________

Verified Discharge Destination Address/Phone Number:____

Discharge Level of Function (ADLs, MOB; Total, Max, Mod, Min, CG):____

Wounds:____

Discharge Needs:____

Home Health Agency:____

DME Ordered:_______________________________ DME Company:____

IVABX/O2/Other:_____________________________ Vendor/Pharmacy Name:_________________________________

Dialysis Provider, Address and Frequency:____

Barriers to Successful Transition to Home/High Risk for Readmission:____

____

Social Determinants of Health Resources Needed/Provided:____

____

Additional Notes:____

PCP Name and Follow-Up Appointment Date/Time:____

Specialist Name and Follow-Up Appointment Date/Time:____

Other Provider Name and Follow-Up Appointment Date/Time:____

Attach physician orders, medication list (including days supply for all medications) and discharge summary.

Signature and Title:____