

PHYSICIAN'S DISCHARGE SUMMARY

Resident: _____

Duration in facility: _____ to _____
Admit Date Discharge Date

Discharged to: _____

Address: _____

City / State / Zip: _____

Phone No.: _____

Transfer / Discharge was necessary due to:

- ☐ The residents welfare and needs cannot be met in the facility.

Medical reason: _____

- ☐ The resident's health has improved sufficiently and no longer needs the services provided by the facility.

- ☐ The health and safety of individuals in the facility would be endangered.

Reason: _____

- ☐ Other: _____

Final Diagnosis: Diagnosis during stay: _____

Discharge Diagnosis: _____

(If different from above) _____

Prognosis: _____

ID Team Representative

Physician / Date