



## HOSPITAL DISCHARGE PLANNER FORM

### PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: (    ) \_\_\_\_\_

*If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.*

Parent/Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Group# \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### MEDICAL HISTORY

Discharging Hospital Name: \_\_\_\_\_

Dates of Hospitalization: \_\_\_\_\_

Discharge Planner Contact Information: \_\_\_\_\_

Revised 6-19-2024

Return Completed Form To: Fax - 586-863-4004

Email - [intake@heliospsych.com](mailto:intake@heliospsych.com)

**PLEASE SEND DISCHARGE PAPERWORK PRIOR TO APPOINTMENT**