

## Patient Discharge Form

Patient Name: \_\_\_\_\_ Date Admitted: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Address: \_\_\_\_\_  
Reason for Admittance: \_\_\_\_\_

Diagnosis at Admittance: \_\_\_\_\_

Treatment Summary: \_\_\_\_\_

Date Discharged: \_\_\_\_\_ Physician Approved? ☐ Yes ☐ No  
Reason for Discharge: ☐ Patient Deceased ☐ Patient Transferred ☐ Patient Terminated w/o Approval  
Diagnosis at Discharge: \_\_\_\_\_

Further Treatment Plan: \_\_\_\_\_

Next Checkup Date: \_\_\_\_\_ Client Consent/Approval? ☐ Yes ☐ No

### Medication Prescribed

Medication	Dosage	Amt.	Frequency	Ending Date

Notes: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date