Hospital Name/Logo Here

Final Discharge Disposition Form

Patient Information

Patient Name _____

Medical Record #_____

Room Number Account Number

Admission Information

Admission Date _____ LOS _____ Insurance _____

Readmit Yes / No Patient Type _____Gender Male / Female

Primary Dx _____ Secondary Dx_____

Attending Physician _____

Post Discharge Services Ordered:

Patient discharge or transfer with a Planned Acute Care Hospital Readmission: Yes / No

Indicate Final DC Disposition:

____Home-w/self-care, relative, group home, foster care, self-admin IV, homeless, RC, Board&Care, ALF ____Short Term Care PPS Facility - Transfer to Acute Hospital ____Medicare Certified SNF Bed - Transfer to Medicare Certified SNF for skilled care ____Non-Medicare Certified SNF Bed - Transfer to Medicare Certified SNF for skilled care ____Short Term Non-PPS Hospital Services - Children's Hospital, Cancer Hosp, Acute Burn Center Facility ____Home Health Services - Answer questions 2-3 to provide more information below

____AMA ____Expired ____Jail or Prison ____Federal Hospital - Includes VA Hospital

_____Home with Hospice ____Hospice Facility

____Medicare Approved Swing Bed, This Hospital & Other Institutions

____Rehabilitation Hospital/Unit - Acute Rehab Facility

____Long Term Care Facility - LTAC at this or other hospital

____Non-Medicare Certified SNF Bed; Medicaid Certified-Medicaid Certified Nursing Home

____Psychiatric Facility/Unit

____Out-patient Services at Other Institution

____Designated disaster alternative care site

____Other Facility Not Classified Above - Provide Name/Type below:

If Home Health, Date Services to Begin:

If Home Health, Reason for Services: ____Related to Reason for Admission

____Unrelated to Reason for Admission

Notes

RN/SW Name: _____

Position: _____

RN/SW Signature: Date: