

Name:		Date of birth:	Age:
Date of admit:		Diagnosis/procedure:	
Date of previous admit:		M.D.:	
M.D.'s admission discharge plan: <input type="checkbox"/> Home <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Other (please specify)			
Comments:			

Primary care provider:	Primary care phone:
Admitting physician:	Admitting physician phone:
Other specialist (e.g., cardiologist):	Specialist phone:
Hospital name:	Hospital tax ID:

Health insurance information	
Primary insurer: ID:	Secondary insurer: ID:
Private/other insurance:	

Significant medical history	
Medications:	Pharmacy of choice: Pharmacy phone:
Prescription given for the following medications: <input type="checkbox"/> Narcotic <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Insulin <input type="checkbox"/> Digoxin <input type="checkbox"/> Aspirin <input type="checkbox"/> Other (please specify): Comments:	
Prior hospitalization: <input type="checkbox"/> Readmit in 30 days of ER visits:	
Medical history: <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Deep venous thrombosis <input type="checkbox"/> Heart failure <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Other:	

Residence	
<input type="checkbox"/> Single family <input type="checkbox"/> Townhouse <input type="checkbox"/> Apt./condo <input type="checkbox"/> Single level <input type="checkbox"/> Multilevel: Number of steps inside home: Number of steps outside home:	<input type="checkbox"/> Lives with other(s); if so, relationship: _____ <input type="checkbox"/> Lives alone <input type="checkbox"/> Needs assistance



Services needed for discharge

Physical therapist Occupational therapist Registered nurse Home health aide

Include physician order and indicate specific service and frequency.

Preferred home rehabilitation services*:

1.

2.

3.

Preferred skilled nursing facility:

1.

2.

3.

Other: (e.g., hospice inpatient/home):

1.

2.

3.

Transportation needs: Private Ambulance Wheelchair van

Indicate company or person:

Contact phone:

Durable medical equipment (DME) needs

Wheelchair Walker Cane Bedside commode Shower chair

Preferred purchase for DME:

1.

2.

3.

Complete information below regarding hospital contact personnel.

Contact person name:

Contact person title:

Contact person phone:

AmeriHealth Caritas District of Columbia Utilization Management (UM)

Customer Service: **202-408-4823** or **1-800-408-7510**

Discharge Planning Fax: **1-855-355-0700**

*Referrals are to be made to participating facilities, providers or Durable Medical Companies. If the provider is non-par, contact AmeriHealth Caritas DC at **202-408-4823** for further assistance or fax **1-855-355-0700**.