DISCHARGE INFORMATION

RESIDENT NAME: ______________________________ **DATE:** ______________

DISCHARGE DESTINATION:

☐ HOSPITAL ☐ NURSING HOME

☐ OTHER COMMUNITY-NAME: ______________________

NOTICE TIME FRAME:

☐ 14 DAY NOTICE

☐ 30 DAY NOTICE

☐ NO NOTICE/IMMEDIATE DISCHARGE

LAST DATE RESIDENT IN HOME: ______________________

FINAL BILLING INFORMATION

NAME ______________________________

ADDRESS ______________________________

TELEPHONE ________________ HOME ______________ WORK

RELATIONSHIP TO RESIDENT: ______________________

DIRECTOR OF RESIDENT CARE SIGNATURE: ______________________________

PLEASE FAX THIS FORM TO THE PHARMACY AS SOON AS THE INFORMATION IS AVAILABLE

FAX NUMBERS: **(912) 489-1519**
(866) 534-5566

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