Figure: Discharge Planning Worksheet

Patient:	Room:	Physician:
Diagnosis: Insurance: Discharge destination: Expected DC date:		Case Manager: Tel: Fax: Last SNF day:

Family/caregiver information:

Equipment owned:

Equipment needed: **MD order needed?**

	YES	NO
_____	____	____
_____	____	____
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Home Health: (circle needs) **PT OT ST RN** ____

Bath aide

No home health