FORM 4

PATIENT'S NAME: _____, _____ **SHELTER:** _____

Please fax to placement/intake site on the day of discharge **FAX NUMBER:** _____

NYC Department of Homeless Services

DISCHARGE FORM FOR SHELTER PLACEMENT and OUTREACH REFERRAL

A. UPDATE OF MEDICATIONS UPON DISCHARGE (to be completed by MD/NP/PA only):
Please note only new medications or changes in medications or dosing compared with original referral.

Medication (generic name, if possible)	Dosage	Route	Frequency*	Disp. #**	Comments (last Dec.? TDM + date?)
1.					
2.					
3.					
4.					

*** Use QD or BID dosing as possible; include dosing for Methadone maintenance (MMTP).**
**** Document whether medications will be supplied or prescriptions given.**

If patient is uninsured, will s/he be supplied with medication? ☐ **Yes** ☐ **No If Yes, for how many days?** _____

B. APPOINTMENTS SCHEDULED FOR MEDICAL AND PSYCHIATRIC FOLLOW-UP:
(Please provide actual appointments or times patient may access clinic without an appointment.)

Service	Date	Time	Clinician or Purpose of Visit	Clinic/Location
MEDICAL:				
SURGICAL:				
PSYCHIATRIC:				
OTHER:				
			MMTP	
			VNS (Agency_____)	Phone: _____

POST-DISCHARGE CONTACT NUMBER: (___) ___-_____ for _____ MD/NP/PA

POST-DISCHARGE CONTACT NUMBER: (___) ___-_____ for _____ SW/RN/DP

POST-DISCHARGE CONTACT NUMBER: (___) ___-_____ for _____ ICM/SCM/ACT Team

POST-DISCHARGE CONTACT NUMBER: (___) ___-_____ for _____ Koskinas Worker

SIGNATURE OF CLINICIAN UPON PATIENT'S DISCHARGE _____