Department of Homeless Services

FORM 5

POST-DISCHARGE REVIEW FORM

I. HOSPITAL AND PATIENT DATA

A. HOSPITAL/FACILITY INFORMATION

Facility Name: _____ **Contact Person** _____

Telephone: (____) _____-_____ x_____ **Pager/Cell:** (____) _____-_____

Fax: (____) _____-_____ **Email:** _____

B. PATIENT INFORMATION

Name: _____ **DOB:** ____/____/____ **SS#:** ____-___-_____

Discharge Date: _____ **Discharged to:** _____

II. POST-DISCHARGE CLINICAL CONCERN(S) and FOLLOW-UP ACTIONS

A. CONDITION(S) OF CONCERN: _____

_____

_____

_____

B. FOLLOW-UP ACTION(S):

1.

2.

3.

4.

5.

C. REVISED DISCHARGE PLAN (if applicable)

Service	Date	Time	Clinician or Purpose of Visit	Clinic/Location

Signature of Treatment Team Member Date

Fax completed form to Dova Marder, MD, Agency Medical Director, NYC DHS Fax: 1-917-637-7372

06/08/10