EMP

MEDICAL SERVICES, INC

DISCHARGE STATUS AND OUTCOME SUMMARY TOOL

Patient's Last Name:

First Name:

DOB: Month Date Year

SSN#:

Telephone #:

Provider Name: _____

Date of Admission : _____ **Date of Last Visit:** _____ **Date of Discharge:** _____

Description	Yes	No	N/A	Comments
Patient has met goals and patient/caregiver is able to assume the responsibility of care?				
Patient admitted to inpatient facility during home care services?				**Date of Admission:**
Patient expired.				**Date:**
Patient/Caregiver has knowledge of their discharge from home health services (NOTE: Notice of Medicare Non-Coverage must have been provided to Medicare Patients).				
Patient refuses any additional services.				

Additional Comments:

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Provider Signature **Date** **Date Faxed to EMP**