INITIAL TRANSITIONAL CARE CONTACT

Patient name: _____

Date of contact: _____/_____/_____

Sources of information:

☐ Patient, family member, or caregiver
(Name: _____)

☐ Hospital discharge summary

☐ Hospital fax

☐ List of recent hospitalizations or ED visits

☐ Other _____

Discharged from: _____
on _____/_____/_____

Diagnosis/problem: _____
_____

Medication changes: ☐ Yes ☐ No

Medication list updated: ☐ Yes ☐ No

Needs referral or lab: ☐ Yes ☐ No

Needs follow-up appointment:

☐ Within seven days of discharge (highly complex visit).

☐ Within 14 days of discharge (moderately complex visit).

Appointment made for _____/_____/_____
with _____

Additional information needed and requested:

☐ Yes: _____

☐ No

Family Practice Management®