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