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

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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