Home Health Agency:_____

5 Day Discharge Notice

To:_____

(Patient's complete name)

You will be discharged from home health services on _____.

The reason for this discharge is _____.

If you should have any problems or questions following your discharge, please contact your primary physician.

It has been a pleasure caring for you and if you have any questions or concerns that we might address, please don't hesitate to contact us at _____.

Notified:_____

(date)

By:_____

(Agency representative)

Patient Signature:_____

(Needed if hand delivered)

Copy sent/faxed to physician ☐ Yes ☐ N/A Date:_____

_____

(Physician name & number)

☐Phone call Date:_____ Patient/SO acknowledges awareness of discharge

(Required if mailed)