Skilled Nursing Facility Discharge Note

Admission date ___ / ___ / ___ Month/Day/Year	Member name (print)	DOB	MHN
	PCP name		
Discharge date ___ / ___ / ___ Month/Day/Year	Address		
	City	State	ZIP

Final diagnosis _____

Reason for admission _____

Significant findings/procedures/treatment rendered _____

Medication: ☐ None

Follow-up care: ☐ Return Clinic visit _____

☐ Other _____

Signature/title

/ /
Date (month/day/year)

☐ AM
☐ PM
Time