Transitional Discharge

Fax to Name _____ Fax Number _____

Patient Contact Information

Name: _____

DOB (mm/dd/yy) ____/____/____

Phone: _____

Assessed by ☐ PERT ☐ Psychiatrist

Admitted to hospital?

☐ Yes Unit: _____ ☐ No

Intervention Provided

Type	Explanation
☐ Medical □ Medication(s) given □ Medication(s) discontinued □ Medications(s) prescribed □ Medical assessment completed □ Other	
☐ Mental Health □ Assessment □ Addiction consult □ Social Work consult □ Inpatient group participation □ Family/Community meeting □ Other	
☐ Referrals □ Call/fax to Mental Health and Addiction Access Line Phone: 1-866-550-5205 Fax: 905-682-7959 □ CCAC □ Internal □ Contact Niagara □ Other	
☐ Other	

Next Steps/Recommendations _____

_____

_____

Discharged to ☐ Current Address ☐ Other _____

Consent to send to: *Please list all agencies*

_____

_____

_____

_____

_____

Patient's signature

Completed by

Name: _____ **Unit:** _____

Phone: _____

Fax: _____

Date: _____ **Time:** _____

Signature: _____