AVEN HOME HEALTH SERVICES
14044 VENTURA BOULEVARD, SUITE 305, SHERMAN OAKS, CA 91423
Phone: (818) 380-0853 FAX: (818) 380-0143

PHYSICIAN'S DISCHARGE ORDER

PATIENT NAME:	MR #:

1) PLEASE DISCHARGE PATIENT FROM HOME HEALTH SERVICE EFFECTIVE DATE: _____

2) REASON FOR DISCHARGE:
- ☐ No Further Skilled Care Needed
- ☐ Physician's Request
- ☐ Patient/Family's Request
- ☐ Refused Further Care
- ☐ Hospitalized at the End of Treatment/Episode
- ☐ Non-Compliance to Plan Of Care
- ☐ Repeatedly Not Found At Home
- ☐ Missed Visit For Three Consecutive Period
- ☐ Geographical Relocation
- ☐ Transferred to Another Home Health Agency
- ☐ Death
- ☐ Others: _____

3) WRITTEN DISCHARGE INSTRUCTION PROVIDED: ☐ Yes ☐ No
IF NO, EXPLAIN: _____

4) GOALS MET/ATTAINED: ☐ Yes ☐ No PARTIALLY MET/ATTAINED: ☐ Yes ☐ No

5) PATIENT/PCG VERBALIZED UNDERSTANDING OF THE DISCHARGE INSTRUCTIONS: ☐ Yes ☐ No ☐ N/A

6) DISCHARGE SAFELY TO: ☐ Self ☐ Responsible PCG/Family ☐ Others: _____

7) CONDITION AT DISCHARGE: ☐ GOOD ☐ Independent in ADL's at home ☐Assist with ADL's/IADL'S

8) RN PERFORMED: ☐ CONTACT ☐ NON-CONTACT OASIS ASSESSMENT

9) ANCILLARY NOTIFIED: ☐ Yes ☐ No ☐ PT ☐ OT ☐ ST ☐ MSW ☐ RD

10) MEDICARE NON COVERAGE OF SERVICES NOTIFICATION ISSUED TO PATIENT: ☐ Yes Date: _____ ☐ No ☐ N/A

RN'S NAME/TITLE/SIGNATURE: _____ Date/Time: _____

PHYSICIAN'S NAME: _____ _____

PHYSICIAN'S SIGNATURE: _____ Date/Time: _____