Request Form

Discharge Information

Patient's Name: ___________________________________ DOB: ________ ID# ________________________

Provider: ____ NPI: ________________________________

Admission Date: ___/___/___ Discharge Date: ___/___/___ Discharged to: _______________________

***Please attach discharge summary and fax to (715) 852-5738.**

Discharge Medications:

Follow-up Appointments:

Other Pertinent Information:

The submission of supporting clinical documentation/plan of care is required with this form.

Privacy and Confidentiality:
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