WVU Physicians of Charleston

Attachment A

REQUEST TO DISCHARGE A PATIENT

Section I (*this section to be completed by the discharging provider*)

Patient to be discharged: _____

MRN: _____

DOB: _____

Address:

_____

_____

_____

Phone #: _____

Name of provider(s) requesting to discharge patient:

_____

Name of department(s) requesting to discharge patient:

_____

Specific reason patient is to be discharged:

_____

_____

_____

Provider Signature: _____

Date: _____

Section 2 *(This section to be completed by Department Administrator)*

Administrator reviewing request: _____

Discharge Letter Sent to General Counsel for Review? Yes _____ No _____

Discharge Letter mailed, return receipt requested? Yes _____ No _____

Return receipt received back from patient? Yes _____ (date) No _____

Date flag entered into IDX: _____

Signature of Administrator:

_____

Date form filed into patient record:

_____