SUMMERFIELD
HEALTHCARE CENTER

FACSIMILE TRANSMITTAL

TO: **FAX:**

FROM: **DATE:**

RE: Orders for Discharge from our Facility **PAGES:**

Mr. /Ms._____ appears ready for discharge: Home____ or RCFE(name)_____ on: _____.

May we have an order to discharge from our facility on: _____ with: HHA___; RN ___; PT ___; or OT__?

_____ YES **_____ NO**

May we have a Rx for the following DME:_____?

_____ YES **_____ NO**

Appointment with Dr._____(PCP) within 1 week of discharge or _____.

Appointments with Dr.(s):_____.

Please reconcile the attached Pre-Hospital and Current SNF Medication Lists and return both to us with this front sheet. Thank You.

_____ _____

PHYSICIAN SIGNATURE **DATE**

1280 Summerfield Road Santa Rosa CA 95405 Phone (707)539-1515 Fax (707)539-0630

If not properly received, please contact (707)539-1515