

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

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