BJC HealthCare

□ BJC Accountable Care Organization
Fax: 314-362-2289
Phone: 314-996-7020, option 5
Toll-Free: 844-996-7020, option 5

Hospital: _____
Fax:
Phone:

BJC ACO 3-DAY SNF WAIVER TRANSITION DISCHARGE CHECKLIST

To be completed and faxed 48 hours prior to discharge

Patient Name:	Patient DOB:
Facility Name/Contact:	Facility Phone:
Discharge Date:	Home Health to follow at Discharge Yes No Home Health Name/Phone:
Disposition:	Discharged Medications Reviewed Yes No With Whom? (Patient, Family, Etc.):
PCP Follow Up Appt Within 7 Calendar Days: Provider Date Time	Medications Given to Patient: Yes No Or Prescriptions Sent In: Yes No If "Yes", Amount of Supply Given (days): 30 60 90
Specialist Follow Up Appt Within 7 Calendar Days: Provider Date Time	Pharmacy Name/Phone: Diet:
Other:	Other Assistance/Referrals: DME/O2 Provider/Phone: DME Supplies:
Special Instructions:	

BJC HealthCare

SNF TRANSITION DISCHARGE CHECKLIST

To be completed by SNF representative and faxed 48 hours prior to SNF discharge

Patient Name_____ Patient DOB _____

Admission Date _____ Diagnosis_____

Facility Name_____ Facility Contact_____ Facility Phone_____

Discharge Medications: may attach facility discharge med list

Name of Medication	Dose	Route	Frequency