MANAGED HEALTHCARE pharmacy since 1991

Phone: 866-367-8701
Fax:866-367-8702

Resident Discharge Form

Resident Name: _____ DOB: _____/_____/_____

Facility Name: _____

Date of Discharge: _____/_____/_____

THIS IS TO INFORM MHP THAT THE ABOVE RESIDENT HAS BEEN DISCHARGED DUE TO:

☐ Death ☐ Hospitalized for more than 72 hrs ☐ Transferred

IF TRANSFERRED TO ANOTHER FACILITY, PLEASE LIST BELOW:

Transferred to: _____
(New Facility)

Staff Signature: _____

Date: _____

Thank you,
Managed Healthcare Pharmacy