☐ BJC Accountable Care Organization
Fax: (314) 996-7656
Phone: (314) 996-7020
Toll-Free: (844) 996-7020

Hospital: ___________________________
Phone: ____________________________
Fax: _______________________________

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: Dr. 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: Dr. Date Time	Pharmacy Name/Phone: Diet:
Other:	Other Assistance/Referrals: DME/O2 Provider/Phone: DME Supplies:
Special Instructions:	

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

Name of Medication	Dose	Route	Frequency

Updated May 2018