Sample Discharge Form

Name of Shelter Guest: Residence Address (street, county, state):	DOB / Age: Gender: Male / Female
Current Location: ❑ Shelter ❑ Nursing Home ❑ Hospital ❑ Hotel ❑ Other:	Current Location: Name, Address (include county, city and state) & Phone
Do you have any chronic/acute health care conditions? ❑ Yes ❑ No	If yes, describe health care condition:

Were you receiving any of the following services/support in your home prior to evacuation or will you need any of the following when you return?

Care/Item	Services Needed	Name and location of pre-hurricane services
❑ Home Health		
❑ Hospice Care		
❑ Durable Medical Equipment		
❑ Physical Therapy		
❑ Oxygen		
❑ Dialysis		
❑ Psychiatric/Psychological		
❑ Other		

Local Jurisdiction Ready For Return? ❑ Yes ❑ No	TYPE OF TRANSPORTATION NEEDED: ❑ Wheelchair accessible ❑ Ambulance ❑ Bariatric capable Ambulance ❑ Bus ❑ Other	Is wheelchair: ❑ Powered ❑ Oversized ❑ Manual Able to fold up: ❑ Yes ❑ No
Needs immediate follow up for medical care? ❑ Yes ❑ No	Needs immediate case management? ❑ Yes ❑ No	Flu shot given? ❑ Yes ❑ No

Destination availability confirmed? ❑ Yes ❑ No ❑ UNKNOWN	Do you need assistance to get to destination? ❑ Yes ❑ No

Return Location: ❑ Home ❑ Assisted Living ❑ Other ❑ Need Shelter	Address (include county, city & state):	Contact Name and Phone:

Do you use oxygen? ❑ Yes ❑ No AMOUNT (flow) _____
Do you have enough oxygen to return home? ❑ Yes ❑ No
Do you have a pet in shelter? ❑ Yes ❑ No Type Pet Name
Have arrangements been made to reunite with pet? ❑ Yes ❑ No

COMMENTS:

Name of Assessor/Data Collector:	Date of Assessment:

State of Texas FNSS Integration Committee. (2015, April). State of Texas functional needs support services tool kit. Retrieved from https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9

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