HELIOS
PSYCHIATRY & COUNSELING

HOSPITAL DISCHARGE PLANNER FORM

PATIENT INFORMATION

Name: _____

Address: _____

DOB: _____Phone: ( )_____

Email address:_____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone: ( )_____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name:_____Relationship:_____

INSURANCE INFORMATION

Insurance: _____ID#_____

Group#_____

Policy Holder's Name: _____Policy Holder DOB: _____

Relationship to Patient: _____

MEDICAL HISTORY

Discharging Hospital Name:_____

Dates of Hospitalization:_____

Discharge Planner Contact Information:_____

Revised 6-19-2024

Return Completed Form To: Fax - 586-863-4004

Email - intake@heliospsych.com **PLEASE SEND DISCHARGE PAPERWORK PRIOR TO APPOINTMENT**