NSCS
North Suffolk
Community Services

Hospital Discharge Referral

Referral Contact Information

Name of Facility		**Referral Date**	
Contact Person Name		**Contact Person Phone #**	
Contact Person e-mail			

In addition to this form, please send the following records:

- Admission Note (note written by medical provider at time admission)
- Psychosocial Assessment
- Recent Progress notes by attending physician/NP
- Discharge Medication List & Allergies
- Labs & EKG (if available)
- Rogers Monitor (If client has a Legal Guardian)

Patient Information

Patient Name		Female ☐ Male ☐ Other ☐	
DOB	/ /	**Insurance Name:** **Policy #:**	
Address (Discharging to)			
Phone Number			
Email Address			
Legal Guardian (Name, relationship, phone #)			
Admission Date			
Anticipated Discharge Date			
PCP Name, Phone & Location			
Language Required		**DMH Involved?**	

***If the patient is prescribed Suboxone, have they been given 2 week Rx? Yes ☐ No ☐**

***Is the patient prescribed any of the following medications below? Yes ☐ No ☐ (Please fill in dates below)**

Medication	Date of Last Injection/Draw	Next Due	Dose	Frequency	Type/Name
Vivitrol					
Long-Acting Injectable Antipsychotic					
Sublocade					
Clozapine					

- Return forms to HospitalDischarges@northsuffolk.org or fax # 617-942-8748.
- Please call 888-309-1989 with questions