

Interfaith House Collaborative Health Partners Medical Stability and Discharge Assessment

Client Name: _____ DOB: _____ Case Manager: _____

Discharge Destination (Name/Type): _____

Location: North South East West Suburbs Unknown Other

Dates Referred for Assessment: _____ Tentative Discharge Date: _____

Admitting Conditions: _____

Conditions Stabilized: Yes No Comments: _____

Physical Assessment: with little difficulty can the client

1. Climb Stairs: Yes No Comments: _____

2. Take public transportation: Yes No Comments: _____

3. Perform light work: Yes No Comments: _____

Future Appointments

Specialists: _____

Scheduled Surgeries/Procedures: _____

Mental Health: _____

Primary Care (date, time, clinic name and location, doctor): _____

Circle below

PCC Austin Family Health Center
5425 W. Lake St.
Chicago, IL 60644
773-378-3347

PCC at Loretto Hospital
645 S Central Ave, Suite 600
Chicago, IL 60644
773-537-0020

PCC Lake Street Family Health Center
14 Lake St.
Oak Park, IL 60302
708-383-0113

PCC Melrose Park Family Health Center
1111 Superior St., Suite 101
Melrose Park, IL 60160
708-406-3040

PCC Salud Family Health Center
5359 W. Fullerton Ave
Chicago, IL 60639
773-836-2785

PCC West Town Family Health Center
1044 North Mozart St., Suite 100
Chicago, IL 60622
773-292-8300

PCC South Family Health Center
6201 W. Roosevelt Rd
Berwyn, IL 60402
708-386-0845

Thomas Huggett, MD Family Practice
Breakthrough Clinic
Lawndale Christian
3219 W Carroll Ave
Chicago, IL 60624
872-588-3580, please ask for Jacqueline Alaniz, Referral Coordinator

Discharge Assessment (prior to leaving): Attach Clinical Summary at client's last visit

Goals needed to be met after discharge: _____

PCP appointment made: Yes No Any pending labs: Yes No

Any issues/concerns prior to discharge: _____

Clinician Signature: _____ Date: _____