STATE OF MICHIGAN

Department of Licensing and Regulatory Affairs
Bureau of Survey and Certification

ESRD INVOLUNTARY DISCHARGE REPORT

CCN #: 23- Date Reported:

Facility Name:

Facility Address:

City: State: Zip:

Discharged Patient Information

Name: Date of Birth:

Per regulations, a patient may be discharged only for the following reasons. Please select the reason that applies

- ☐ Failure to pay for services.
- ☐ Facility ceases to operate.
- ☐ Facility can no longer meet the patient's documented medical needs.
- ☐ Patient's behavior is disruptive and abusive to the extent that delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired.

Please provide detailed information

Required Discharge Notifications Made by Facility

Step Taken	Date	Step Taken	Date
Medical Director Notified.		Contacted another facility to attempt to place the patient.	
Documentation of reassessments, ongoing problems and efforts to resolve problem entered in patent record.		Provided patient 30 day notice* of discharge. *__ATTACH A COPY OF WRITTEN NOTICE__	
Written physician's order obtained signed by both the medical director and the patients attending physician concurring with the discharge or transfer.		Contacted Renal Network 11 and provided network with a copy of the 30 day written notice.	

Facility Administrator Information

Name: Title:

Phone/Fax: Email:

Signature: _____ Date: _____