Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
www.HorizonBlue.com

Transition Checklist for Horizon BCBSNJ Patients
Hospital Discharge Form

Please complete this form and fax it to your Horizon Blue Cross Blue Shield of New Jersey nurse prior to patient hospital discharge.

Patient Name: ______________________________ ID Number: ______________________________

Facility Name: ______________________________ Discharge Date: ______________________________

Disposition upon discharge: ☐ Home ☐ Post Acute Facility

	(Please check one) Yes	No	N/A
Does the patient have appropriate support upon discharge?	☐	☐	☐
If yes, please specify:			
Caregiver's name: ______________________________			
Caregiver's phone number: ______________________________			
Days/hours available: ______________________________			
Is the home environment patient-friendly (e.g., home access, stairs, entry access)?	☐	☐	☐
Can the patient perform activities of daily living (ADLs) independently (e.g., self-care, stair climbing, cooking, light housework)?	☐	☐	☐
Are medication prescriptions available and complete?	☐	☐	☐
How will the patient obtain the medication needed? ______________________________			
Did the patient receive instructions about new and existing medications prior to discharge?	☐	☐	☐
Name of physician providing follow-up care: ______________________________			
Physician's phone number: ______________________________			
Follow-up appointment date: _____/_____/______			
Are post discharge services required?	☐	☐	☐
If yes, please specify:			
Home RN services: ______________________________	☐	☐	☐
Home PT services: ______________________________	☐	☐	☐
Home OT services: ______________________________	☐	☐	☐
Home Infusion Therapy: ______________________________	☐	☐	☐
Outpatient follow up (e.g., PT, radiology): ______________________________	☐	☐	☐
Re-admission case?	☐	☐	☐

Risk factors identified to prevent readmission:

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Comments:

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