WellnessPointe
Family Health Starts Here
Longview Wellness Center, Inc.

Request to Discharge Patient from Care

Complete and return to Compliance & Performance Improvement Department

Patient Information

Patient Name: _____

Patient ID Number: _____ Patient Date of Birth: _____

Parent/Guardian Name (if minor patient): _____ Correct Telephone Number: _____

Correct Mailing Address (Street, City, State, ZIP): _____

Reason for Discharge

☐ Repeated non-compliance with provider orders ☐ Disruptive behavior

☐ Failure to keep appointments ☐ Mistreatment of Center staff

☐ Unable to provide necessary services/treatment ☐ Violation of Center policy

Provide specific incidents (including dates) that led to your decision to discharge the patient:

Date: / /

Date: / /

Date: / /

Describe steps you have taken to avoid discharging the patient:

Requesting Provider Information

Print Name: _____

Department/Clinic: _____ Date of Request: _____

Provider Signature: _____

Corporate Approval

Management Signature: _____

Date of Certified Letter: _____ Sender: _____

Date of Receipt: _____ Date Filed in Record: _____