



**Attachement Form B:  
Patient Discharge  
Care Notification Form**

Date:	
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Patient name:		ID number:	
Referring plan:			
Date of transplant:		Type of transplant:	
CME dates:		to:	
Institution:		Date of discharge:	

Hospital		Referring plan	
Signature:		Signature:	
Print name:		Print name:	
Title:		Title:	
Date:		Date:	

**After completion of form:** Fax one copy to the Referring or Transplant Coordinator. Refer to the *Referring and Servicing Contact List* in the Procedure Manual. Keep one copy for your records.