REGIONAL SHELTER COMMAND OPERATIONS

SHELTER CLIENT DISCHARGE FORM

Date/Time:	Shelter Name/City/State

Staff Information

Destination

Transportation Needs

Discharge Checklist

Name of Person Completing this form

Equipment and Supplies Returned with Client

Resident Information

Resident Name:	Resident ID Number
Home Address	Phone

Caregiver Name (if applicable)

Caregiver Relationship to Client	Phone

Number of family members discharged with Client:

Name	**Resident ID**	**Relationship to Resident**

☐ Home	☐ Nursing Facility	☐ Hospital	☐ Hotel
☐ Apartment	☐ Retirement Facility	☐ Family	☐ Caregiver
☐ Shelter	☐ Friend	☐ Hospice	
☐ Other (explain)			

Name of Destination Facility

Address

Phone Email

Alternate Point of Contact Name Phone

☐ Car ☐ Bus ☐ Accessible Vehicle ☐ Ambulance ☐ Other

Describe

☐ Electricity ☐ Heat ☐ Road Clear ☐ Client Physically Able to Travel

☐ Medication Describe:

☐ Equipment Describe:

☐ Personal Items Describe:

Forwarding Address of Client

Additional Comments