Your Hospital's Logo Here

PATIENT DISCHARGE LIST

PATIENT IDENTIFICATION

UNIT: ***LABOR & DELIVERY***

DISCHARGE DATE:

PATIENT NAME	**Thinned Record Number**	**Date of Charges**	**Received by HIM (Yes / No) & COMMENTS**	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

INSTRUCTIONS: To be Signed + Dated by H.I.M. Staff (and) Nursing Department Representative

NURSING UNIT Signature: DATE:

H.I.M. STAFF Signature: DATE:

PART OF THE MEDICAL RECORD