

Today's Date: \_\_\_\_\_

## State Notification of Involuntary Discharge/Transfer

Department of Health Services Licensing and Certification County Office: \_\_\_\_\_

Attention (ESRD Supervisor): \_\_\_\_\_ Fax Number: \_\_\_\_\_

Facility CCN: \_\_\_\_\_ Facility Name \_\_\_\_\_

Name of individual making the report: \_\_\_\_\_

Event:            Involuntary Discharge (IVD)     Involuntary Transfer (IVT)

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Date of Discharge or Transfer (patient's last date of treatment): \_\_\_\_\_

Reason for IVD or IVT:

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Was the Network Notified?    YES             NO

Date Network Notified: \_\_\_\_\_            Network Staff Notified: \_\_\_\_\_

For additional information you may contact the above stated Network staff at:

1-888-268-1539  
700 N. Brand Blvd, Suite 370  
Glendale, CA 91203



Items Attached:

- IVD/IVT Notice given to Patient
- Medical Director and Attending Nephrologist written Discharge Order