REVIEWED BY ATIP DIVISION
Correctional Service of Canada
RÉVISÉ PAR LA DIVISION AIPRP
Service correctionnel du Canada

Hospital Discharge Form
Physician Recommendations for Medical Isolation

AFFIX PATIENT IDENTIFIER STICKER HERE

Patient Name: ______________________________

Date of hospitalization: ____________________ Date of discharge: ____________________

Current COVID-19 Outbreak at Hospital:	□ Yes □ No
To your knowledge, was the patient exposed to COVID-19 while in the hospital:	□ Yes □ No
COVID-19 test while in hospital: □ Negative □ Positive □ Not tested	Date of test:______________________
Do you recommend medical isolation for this patient upon returning to a federal correctional institution (which is a congregate living environment, similar to a long-term care home)? □ No □ Yes, I recommend the patient be medically isolated for ___ days, until __________ (YYYY/MM/DD) **Rationale for recommendation regarding medical isolation requirement:** ______________________________ ______________________________	

Full Name of Discharging Physician (please print): ______________________________

Physician Signature: ______________________ Date: ____________________

(Form version 2020-08-26)