Division of Immigration Health Services SSU Admission and Discharge Form

Date of Admission:_____ Time of Admission:_____

Provisional Diagnosis: _____
Mental Status: _____
_____

Physical Condition: _____

Diet: _____ Regular _____ Other _____

Medication(s): _____ No _____ Yes/Specify _____
_____

Activities: _____ Full _____ Other/Specify _____
_____

Special Needs: _____ None _____ Yes/List _____
_____

Cafeteria Privileges: _____ Authorized _____ Not Authorized _____
_____

Comments: _____
_____
_____

Date of Discharge:_____ Time of Discharge:_____ Total No. of Days in the Infirmary:_____

DIAGNOSES LISTED IN ORDER OF IMPORTANCE

_____

OTHER PROCEDURES

_____

Disposition:
_____: Return to General Population
_____: Transfer to:_____
_____: Other: _____
_____: Died - Date of Death:_____

_____ _____ _____
Signature of Provider *(Stamp) Printed Name of Provider* *Date*

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:

1. Name: (Last) (First)	
2. DOB:	3. A #
4. Nationality:	5. Facility:

DIHS-837 (Rev 01/01)