

Manitoba Developmental Centre (MDC)
AGENCY DISCHARGE PROTOCOL

Name: _____

MDC requires that the following has been completed by agency or community care provider.

Please complete and return to Clinical Coordinator:

☐ The resident's Care Guide, Individual Plan, Behaviour Support Plan (if applicable), and the Resident Profile have been communicated to and understood by agency staff/caregivers.

☐ Staffing is in place prior to any visits by the resident (including overnight staff if applicable).

☐ Home Address: _____

Home Phone Number: _____

☐ Community **physician** confirmed. **Initial appointment must occur prior to or on discharge date.**

Name of physician: _____

Contact information: _____

☐ Community **psychiatrist** confirmed (if applicable).

Name of psychiatrist: _____

Contact information: _____

☐ Community **dentist** confirmed.

Name of dentist: _____

Contact information: _____

Date: _____

Signature: _____

Printed Name: _____

Agency & Title: _____