**Attachment 2**

Meeting Minutes of Discharge Support Board for Patients Hospitalized for Medical Care and Protection

Committee meeting mm/dd/yyyy

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient name |  | Date of birth |  MM | DD | YYYY |
| Name of Post-Discharge Life Counselor |  |
| Current length of hospitalization | From MM | DD | YYYY | To  | MM | DD | YYYY |
| Attendees | Doctor in Charge ( )Nursing Staff ( )Post-Discharge Life Counselor ( )Patient him/herself (attendance/absence)Family, etc. ( (Relationship: ) )Others ( ) |
| Opinions of the patient and his/her family, etc. |  |
| - Whether or not there is a need to continue the hospitalization period and the reason given- Specific efforts toward discharge from the hospital |  |  | Yes | / |  | No |  |  |
|  |
| Hospitalization period after continuation has been determined\*The period must be within three months if six months have passed since hospitalization, and within six months after six months have passed. |  |  | Until MM | DD | YYYY |  |
| Other |  |

[Signature of Hospital Administrator: ]

[Signature of Recorder: ]