**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: ]