

BAR CODE LABEL

RUSH UNIVERSITY MEDICAL CENTER  
Chicago, Illinois

**PATIENT PASS FOR TEMPORARY ABSENCE  
FROM THE MEDICAL CENTER**

It is the policy of Rush University Medical Center to permit Patient Passes only when there is a medical or therapeutic reason for doing so. The maximum length of time a patient may be on a pass is six hours. All patients must be in their rooms by midnight of the day the pass is granted.

1. \_\_\_\_\_ has been granted permission to leave Rush University Medical Center by Dr. \_\_\_\_\_

Date \_\_\_\_\_ from \_\_\_\_\_ AM/PM to \_\_\_\_\_ AM/PM

2. Reason Pass is being granted (only medical or therapeutic reasons are automatically acceptable).

- To attend the funeral and/or wedding of immediate relative (i.e., parent, child, spouse).
- To examine future placement environment (i.e., nursing home to be transferred to upon discharge).
- To promote mental and emotional well being.
- To receive treatments, diagnostic tests, and consultations not available at the facility.
- As a definitive part of the treatment plan for psychiatric or rehabilitation care.

3. Medical Instructions \_\_\_\_\_  
\_\_\_\_\_

Medications Instructions \_\_\_\_\_  
\_\_\_\_\_

**I understand that it is important that I not take any medication or drugs which have not been prescribed by my physician, consume any alcohol, or engage in any other activity which may adversely affect my treatment upon return to the Hospital. I understand that it is very important that I return to the Hospital at the time specified on the Pass. I further understand that if I do not return as specified on the Pass, I will be voluntarily discharged and considered to have left the Hospital against medical advice, in which case I release Rush University Medical Center, its officers, agents and employees from any and all liability which may result from my failure to return. I also understand that if my insurance policy does not cover the period of time during which I am on a Patient Pass, I must assume responsibility for payment.**

Patient Signature \_\_\_\_\_  
(or parent/guardian of minor patient)

Physician Signature \_\_\_\_\_

RN Signature \_\_\_\_\_

Date \_\_\_\_\_ and Time \_\_\_\_\_ AM/PM of actual patient departure.

Date \_\_\_\_\_ and Time \_\_\_\_\_ AM/PM of actual patient return.

UTILIZATION REVIEW DEPARTMENT:

Criteria Met

Criteria Not Met

\_\_\_\_\_  
Signature U/R Representative

\_\_\_\_\_  
Date