DISCHARGE SUMMARY FORM

Please complete all information requested on this form. Fax to 1.844.263.1379

DISCHARGE CONSULTATION INFORMATION

Member Name _____

Member DOB _____

Member ID # _____

Member Address _____

Facility Name: _____

Facility Fax Number: _____

Member Phone: _____

Parent / Guardian Name: _____

Best Time to Reach Member/Parent/Guardian: _____

UM Name: _____

Emergency/Other Contact: _____

Outpatient Therapist _____

Outpatient Therapist Phone _____

Date of next appointment _____

Case Manager (if applicable) _____

Case Manager Phone _____

Psychiatrist _____

Psychiatrist Phone _____

Date of next appointment _____

Does the member have medication to last until this follow-up? ❑ **Yes** ❑ **No**

Other follow-up appointments: _____

Name/Type of Provider: _____ **Phone:** _____

Date of next appointment: _____

*** All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to the Utilization Review manager to obtain for assistance with the appropriate level of follow-up.

Medical Provider/PCP _____ **Phone** _____

Current ICD Diagnosis

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Medication at discharge _____

Discharge Disposition/Where will member reside after discharge? Please provider a description of the member's care plan and living arrangements after discharge.

_____ _____

Signature of Facility Staff **Signature of Facility Staff**

_____ _____

Date of Admission/Discharge **Time of Admission/Discharge**

SUBMIT TO
Utilization Management Department
FAX: 1.844.263.1379