DISCHARGE CONSULTATION 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: _____Did member attend a 513 (Bridge appt. during the discharge process? ❑ Yes ❑ No

If yes, name of staff conducting the 513: _____

Phone: _____ Date of the 513: _____ Time of the 513: _____

***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 Cenpatico to allow 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 be staying after discharge?

_____
Signature of Facility Staff

_____
Signature of Facility Staff

_____
Date of Admission/Discharge

_____
Time of Admission/Discharge

SUBMIT TO
Utilization Management Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Phone: 1.800.704.1483
FAX: 1.844.263.1379