

DISCHARGE CONSULTATION DOCUMENTATION
Please complete all information requested on this form. Fax to 1.866.535.6974

DISCHARGE CONSULTATION INFORMATION

Member Name _____ Member Phone: _____
Member DOB _____ Parent / Guardian Name: _____
Member ID # _____ Best Time to Reach Member/Parent/Guardian: _____
Member Address _____ Facility UM Contact Name: _____
Facility Name: _____ Emergency/Other Contact: _____
Facility Fax number: _____

Outpatient Therapist _____ Psychiatrist _____
Outpatient Therapist Phone _____ Psychiatrist Phone _____
Date of next appointment _____ Date of next appointment _____
Case Manager (if applicable) _____ Does the member have medication to last until this follow-up?
Case Manager Phone _____ ☐ 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 healthplan to allow for assistance with the appropriate level of follow-up.

Medical Provider/PCP _____ Phone _____

Current ICD Diagnosis

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Danger to Self or Others (if yes, please explain)? ☐ Yes ☐ No

MSE within normal limits (if no, please explain)? ☐ Yes ☐ No

Medication at discharge _____

Discharge Disposition/Where will member be staying after discharge?

My signature below certifies that I have agreed to release the information contained here to my PCP and behavioral health providers. My consent is voluntary, can be revoked in writing at any time, and will be used to assist with providing referrals, resources and support related to substance abuse treatment.

Signature of Facility Staff

Signature of Member/Guardian

Date of Admission/Discharge

Time of Discharge

SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.535.6974