SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.535.6974

DISCHARGE CONSULTATION DOCUMENTATION

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

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: ____________________

Facility UM Contact 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 healthplan to allow for assistance with the appropriate level of follow-up.

Medical Provider/PCP ______________________________ Phone ______________________________

Current ICD Diagnosis

Primary ______________________________

Secondary ______________________________

Tertiary ______________________________

Additional ______________________________

Additional ______________________________

Dance 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

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