AmeriHealth Caritas Louisiana

Behavioral Health Discharge Note (Behavioral Health Inpatient)

Please fax to **1-855-301-5356** 24 hours prior to discharge.

Today's date:		
Contact information		
Member name:	Member ID number:	Member date of birth:
Member address:		Member phone number:
Name of facility:		Facility NPI provider number:
Date of admission:	Discharged to home, foster care, shelter, etc.:	
Date of discharge:	Discharge address:	
Discharge phone number:	If a minor or dependent adult, name of parent/guardian and contact information:	

ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):	
Was this discharge against medical advice (AMA)?	☐ Yes ☐ No
Was discharge information sent to the primary care provider/psychiatrist?	☐ Yes ☐ No
Was discharge plan discussed with member?	☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to parent/guardian?	☐ Yes ☐ No

Were any of the following included in the discharge plan? Complete all that apply.	
Referral to shelter	**Assisted living facility**
Provider name:	Provider name:
Address:	Address:
Phone number:	Phone number:
Contact person if known:	Contact person if known:

Permanent supportive housing (PSH) Provider name: Address: Phone number: Contact person if known:	**Mental health rehabilitation services** Provider name: Address: Phone number: Contact person if known:
Referral for substance use disorder treatment Provider name: Address: Phone number: Contact person if known:	**Assertive community treatment services** Provider name: Address: Phone number: Contact person if known:
Electroconvulsive treatment services (ECT) Provider name: Address: Phone number: Contact person if known:	**Other (MH therapy, medical management, AA, NA):** Provider name: Address: Phone number: Contact person if known:

Collaboration of needs: please indicate if collaboration is needed with any of the services below. Please include contact name and phone number:

	Yes	No	Contact information
Child or adult protective agency	☐	☐	
Jail/prison/court system	☐	☐	
Juvenile justice	☐	☐	
Nursing or nursing home facility	☐	☐	
Residential program	☐	☐	
School system	☐	☐	
Other	☐	☐	

Discharge medications include all medications, including medical. (Please provide dose, frequency, and condition for which medication is prescribed.) **Please also note, if applicable, the next scheduled injection for any appropriate medication.**

Are these medications on the formulary or do they require precertification?	☐ Yes ☐ No
Has precertification been received if needed?	☐ Yes ☐ No

Risk assessment (if no, explain)
Was the member stable at discharge? (no risk for suicide, homicide, psychosis)

Aftercare appointment 1 (must be within seven days)	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? ☐ Yes ☐ No If no aftercare appointment is scheduled within seven calendar days, please explain why below:	

Aftercare appointment 2	
Provider name:	Provider contact number:
Date of appointment:	Time of appointment:
Comments:	
Form submitted by:	
Phone number of person submitting form:	Date form submitted:

Important note: You are not permitted to use or disclose protected health information (PHI) about individuals who you are not currently treating or are not enrolled to your practice. This applies to PHI accessible in any online tool, sent in any medium including mail, email, fax, or other electronic transmission.