AmeriHealth Caritas
Louisiana

Substance Abuse Discharge Note (Detoxification and residential halfway house treatment)

Important note about detoxification admissions: Please fax to **1-855-301-5356** 24 hours prior to discharge with admission and discharge information, as detox admissions are **notification only.** AmeriHealth Caritas Louisiana BH UM will call or fax you an authorization number once the form is accepted.

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:	

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 the 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

ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):

Please complete ASAM rating at time of discharge
Dimension 1: Acute intoxication or withdrawal potential: Explain:
Dimension 2: Biomedical conditions and complications: Explain:
Dimension 3: Emotional, behavioral, or cognitive conditions and complications: Explain:
Dimension 4: Readiness to change: Explain:
Dimension 5: Relapse, continued use, or continued problem potential: Explain:
Dimension 6: Recovery environment: Explain:
Is member stepping down to a lower level of substance abuse care: Yes No If so, what level of care: If provider is requesting a step-down level of care, we recommend calling BH UM to provide discharge information and complete a clinical review for an authorization in the step-down level of care.

Discharge medications include all medications, including medical. (Please provide dose, frequency, and condition for which medication is prescribed).	
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

Was the member transitioned to a lower level of care? Yes No

If yes, please provide specifics below (i.e., level of care, expected start date, and expected duration of treatment):

If no, please explain:

Any other providers involved in the aftercare plan? If yes, please list below with contact information.

Form submitted by:	
Phone number of person submitting form:	Date form was 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.