

Substance Use Discharge Note

(Inpatient detoxification, substance use disorder rehabilitation, and halfway house)

Please fax to behavioral health Utilization Management (BH UM)
department: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Today's date:

CONTACT INFORMATION		
Member name:		
Member ID number:	Member date of birth:	Member phone number:
Member address:		
Name of facility:		
Facility NPI number:	Date of admit:	Date of discharge:
Location discharged to (e.g., home or shelter):		Discharge phone number:
Discharge address:		
If a minor or dependent adult, name and contact information or any other pertinent contact information:		

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

COLLABORATION OF NEEDS Please indicate if collaboration is needed with any of the below, and include contact name and phone number:	
Adult protective agency: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
Jail, prison, or court system: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
Long-term services and supports (waiver programs): <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
Nursing or nursing home facility: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
Residential program: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
PROMISE program : <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:
Other : <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact information:

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LIST DISCHARGE MEDICATIONS (INCLUDE ALL MEDICATIONS).

(Please provide the dose, frequency, and condition for which each medication is prescribed.)

Are these medications on the formulary or do they require precertification? ☐ Yes ☐ No

Has precertification been received if needed? ☐ Yes ☐ No

DESCRIBE RISK ASSESSMENT (if there has been no risk assessment, please explain).

Was the member stable at discharge, with no risk for suicide, homicide, or psychosis? ☐ Yes ☐ No

FOLLOW-UP AND/OR TRANSITION TO A LOWER LEVEL OF CARE

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

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

If there has been no follow-up or transition, please explain:

ARE ANY OTHER PROVIDERS INVOLVED IN THE AFTERCARE PLAN? If yes, please list below with contact information:

Name of the person submitting form:

Phone number of the person submitting form:

Date form submitted