home state health

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: _____

UM 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: _____ Did member attend a 510/513 (Bridge appt. during the discharge process? ☐Yes ☐No

if yes, name of staff conducting the 510/513 _____

Phone: _____ Date of the 510/513:_____ Time of the 510/513 : _____

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 _____

Medication at discharge _____

Discharge Disposition/Where will member be staying after discharge?

_____
Signature of Facility Staff

_____
Signature of Member/Guardian

_____
Date of Admission/Discharge

_____
Time of Discharge

SUBMIT TO
Utilization Management Department
Phone: 1.866.864.1459
Fax: 1.866.535.6974