MENTAL HEALTH DISCHARGE SUMMARY/BILLING FORM

DATE: ___________________   RU#: _______________   CODE ACTIVITY: ☐315 PD ☐571 CMPD ☐364 MD PD ☐540 NonBill MHS

STAFF #: ___________________   HOURS: ___________   MINUTES: ___________

LOCATION: (please ☐) ☐ Office ☐ Field ☐ Phone ☐ Home ☐ School

1. DISCHARGE DIAGNOSIS: ________________________________________________________

2. COURSE OF TREATMENT:
   a. Opening and Closing Date: ____________________________________________________
   b. Referral Source (reason for admission): ________________________________________
   c. Discharge Medications (include dosage and schedule, response, compliance, side effects, adverse labs, and other medication issues): ________________________________________________________
   d. Allergies: __________________________
   e. Outcome (treatment highlights, modalities of treatment, goals obtained): ___

3. DISCHARGE PLANS:
   a. Recommendations: ____________________________________________________________
   b. Possible Future Problems: ____________________________________________________
   c. Referrals Out: ______________________________________________________________

Date: ___________   Signature: ___________________________   License/Title: ________________
Co-Signature: ___________________________   License/Title: ________________

Date: ___________   (if applicable)   License/Title: ________________

USE REVERSE SIDE FOR ADDITIONAL INFORMATION

MHC022 (Rev. 7-13) Discharge Summary/Billing Form

Computer Entry Clerical Initials