



Network Provider Discharge Form

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| Consumer Name: |
| Consumer DOB: |
| Consumer MRN: |

Discharge Date _____ Provider Name _____

Facility/Place of Service – Location (City) _____ Group Name (if applicable) _____

Legal Class at Discharge W60000 Voluntary

Residential Living Arrangement: (check one response)

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| <input type="checkbox"/> Adult Residential Facility <input type="checkbox"/> Alcohol Abuse Facility <input type="checkbox"/> Community Treatment Facility <input type="checkbox"/> Crisis Residential Facility <input type="checkbox"/> Drug Abuse Facility <input type="checkbox"/> Foster Family Home <input type="checkbox"/> Group Home (Level 1-12 Child) | <input type="checkbox"/> Group Quarters <input type="checkbox"/> Homeless - No Residence <input type="checkbox"/> Homeless, No Identifiable Residence <input type="checkbox"/> House or Apartment <input type="checkbox"/> House or Apt. with Supervision <input type="checkbox"/> House or Apt. with Support <input type="checkbox"/> Justice Related | <input type="checkbox"/> Large Board & Care <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with others <input type="checkbox"/> Lives with relatives <input type="checkbox"/> Other <input type="checkbox"/> Res Tx Cntr (Level 13-14 Child) | <input type="checkbox"/> Satellite Housing <input type="checkbox"/> Single Room <input type="checkbox"/> Small Board & Care <input type="checkbox"/> Supported Housing <input type="checkbox"/> Temporary Arrangement <input type="checkbox"/> Unknown / Not Reported |
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| Substance Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | SU ICD-10 Diagnosis Code: F | Employment Status: (check one response) |
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| Discharge Reason: | | <input type="checkbox"/> Full time, 35 hours or more per week (comp) <input type="checkbox"/> Part time, less than 35 hours per week (comp) <input type="checkbox"/> Homemaker, Not Seeking Work <input type="checkbox"/> Unemployed, actively looking for work <input type="checkbox"/> Other <input type="checkbox"/> Resident / Inmate of institution <input type="checkbox"/> Retired <input type="checkbox"/> Student, Full Time <input type="checkbox"/> Unknown / Not Reported | <input type="checkbox"/> Volunteer Worker <input type="checkbox"/> Disabled <input type="checkbox"/> Full time, 35 hours or more per week (non-comp) <input type="checkbox"/> Homemaker, Seeking Work <input type="checkbox"/> Part time, less than 35 hours per week (non-comp) <input type="checkbox"/> Student, Employed Part Time <input type="checkbox"/> Student, Part Time <input type="checkbox"/> Unemployed, not seeking wrk <input type="checkbox"/> Full-time training <input type="checkbox"/> Part-time training |
| <input type="checkbox"/> Completed Tx/Goals Reached/Referred <input type="checkbox"/> Completed Tx/Goals Not Reached/Referred <input type="checkbox"/> Mutual Agreement - Treatment Goals partially met <input type="checkbox"/> Mutual Agreement - Treatment Goals Not Met | <input type="checkbox"/> Client Withdrew, AWOL, AMA, TX Goals partially met <input type="checkbox"/> Client Withdrew, AWOL, AMA, No Improvement <input type="checkbox"/> Client Deceased <input type="checkbox"/> Client Moved Out of Area <input type="checkbox"/> Client incarcerated <input type="checkbox"/> Client Discharged, Administrative <input type="checkbox"/> Other | | |

Discharge Status:

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| <input type="checkbox"/> Still a patient or expected to return <input type="checkbox"/> Discharged to home, self-care, foster care, shelter care <input type="checkbox"/> Unplanned discharge <input type="checkbox"/> Discharged/transferred to Jail <input type="checkbox"/> Other <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> Left against medical advice <input type="checkbox"/> Deceased | <input type="checkbox"/> AWOL <input type="checkbox"/> Discharged/transferred to Residential/Board and Care (not locked, supervised living, no treatment) <input type="checkbox"/> Discharged/transferred to Community Residential Treatment (not locked, custodial) <input type="checkbox"/> Discharged/transferred to Community Treatment Facility (locked, no nursing care) <input type="checkbox"/> Discharged/transferred to Skilled Nursing Facility/ Intermediate Care Facility (unlocked or locked) | <input type="checkbox"/> Discharged/transferred to Acute Care Hospital or Psychiatric Health Facility (PHF) <input type="checkbox"/> Discharged/transferred to State Hospital <input type="checkbox"/> Discharged or transferred to another short term hospital <input type="checkbox"/> Discharged or transferred another type of institution <input type="checkbox"/> Left against medical advice <input type="checkbox"/> Discharged/ transferred to medical unit |
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Referred To: (may choose up to 3)

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| <input type="checkbox"/> Self <input type="checkbox"/> Mental Health Access Line <input type="checkbox"/> Low Fee Mental Health Clinic <input type="checkbox"/> Family <input type="checkbox"/> Central County Adult OP | <input type="checkbox"/> Central County Children SVS <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Community Based Organization <input type="checkbox"/> Dept. Social Services – Foster <input type="checkbox"/> East County Adult OP | <input type="checkbox"/> East County Children’s SVS <input type="checkbox"/> Jail <input type="checkbox"/> Juvenile Hall <input type="checkbox"/> Kaiser <input type="checkbox"/> Referral Data Missing/NA | <input type="checkbox"/> School/College <input type="checkbox"/> West County Adult OP <input type="checkbox"/> West County Children SVS <input type="checkbox"/> Other |
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Beneficiary instructed by: (check all that apply) Phone Voice Mail In Person By Letter; that if Mental Health Services are needed in the future to: Call this Provider Call their Social Worker Call the Access Line @ 1-888-678-7277

Treatment Summary / Discharge Plan / Additional Info:

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| ICD-10 Code: F | DSM5 Description: | |
| Signature/License | Printed Name | Date |