DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form. Fax to 844-528-3453

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 513 (Bridge appt. during the discharge process? Yes ☐ No ☐

If yes, name of staff conducting the 513: _____

Phone: _____ Date of the 513: _____ Time of the 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 Cenpatico 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: 866-329-4701
FAX: 844-528-3453