AmeriHealth Caritas
District of Columbia

Behavioral Health Discharge Note

Behavioral health inpatient

Date: **Please fax to 1-855-410-6638 24 hours before discharge.**

Contact information

Member name:	Member ID number:	Member date of birth:
Member address:		Member phone number:
Name of facility:		Facility NPI number:

Date of admit:	Discharged to (home, foster care, shelter, etc.):
Date of discharge:	Discharge address:
Discharge phone number:	If a minor or dependent adult, name and contact information of parent or guardian:

ICD-10 discharge diagnoses (psychiatric, substance use, and medical)

Was this discharge against medical advice (AMA)?	☐ Yes ☐ No
Was discharge information sent to the primary care provider or psychiatrist?	☐ Yes ☐ No
Was the discharge plan discussed with the member?	☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? (This is also applicable for adults who have legal guardians.)	☐ Yes ☐ No

Were any of the following included in the discharge plan? (Complete all that apply.)

Referral to patient discharge coordination team (McClendon for adults, Family Matters for children)? Comments:	☐ Yes ☐ No ☐ Refused
Referral to Addiction Prevention and Recovery Administration (APRA) at **202-698-6080**? Comments:	☐ Yes ☐ No ☐ Refused

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

Were any of the following included in the discharge plan? (Complete all that apply.)	
Department of Behavioral Health? Comments:	☐ Yes ☐ No ☐ Refused
Other (mental health therapy, medical management, Alcoholics Anonymous, Narcotics Anonymous)? Provider name: Address: Phone number:	☐ Yes ☐ No ☐ Refused

Collaboration of needs (Please indicate if collaboration is needed with any of the below, including contact name and phone number.) Check all that apply.

	Yes	No	Contact information
Child or adult protective agency			
Jail, prison, or court system			
Juvenile justice			
Nursing or nursing home facility			
Residential program			
School system			
Other			

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Discharge medications (Include all medications, including medical. Please provide dose, frequency, and condition for which each medication is prescribed.)	
Are these medications on the formulary?	☐ Yes ☐ No
Do these medications require precertification?	☐ Yes ☐ No
Has precertification been received, if needed?	☐ Yes ☐ No

Risk assessment (If no risk assessment was performed, please explain.)
Was the member stable at discharge (no risk for suicide, homicide, or psychosis)?

Aftercare appointment 1 (must be within seven days)	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? If no aftercare appointment is scheduled within seven calendar days, please explain why:	☐ Yes ☐ No

Aftercare appointment 2	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Comments:	

Provider/facility notice:
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Are any other providers involved in the aftercare plan? (If yes, please list below with contact information.)
Form submitted by:
Phone number of person submitting form:
Date form submitted:

Provider/facility notice:
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