Companion
BENEFIT ALTERNATIVES

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Discharge Form

Please complete the entire form. A timely response will help to ensure continuity of care for the patient.

Patient's Name: _____ ID Card Number: _____

Patient's Phone Number: _____ ☐ Home ☐ Cell

Facility: _____

Type of Service Approved: _____

Information Provided By: _____

Date of Admission: _____

Discharge Diagnosis:

Axis I: _____

Axis V: _____

Date of Discharge: _____ Actual Length of Stay: _____

Total Days Approved for Current Level of Care: _____ Discharge Placement: _____

Did the patient leave AMA? ☐ Yes ☐ No If yes, please provide date: _____

Were the member's follow-up appointment(s) scheduled within seven days after discharge? ☐ Yes ☐ No

Discharge Medications (include both over-the-counter and prescription):

1. _____ 2. _____

3. _____ 4. _____

Follow-up information: Please check all that apply:

☐ Psychiatrist's Name and Phone Number: _____ Date: _____

☐ Therapist's Name and Phone Number: _____ Date: _____

☐ Other Name and Phone Number: _____ Date: _____

☐ AA/NA ☐ No Follow Up Planned – Reason: _____ ☐ No Information Available

☐ PHP ☐ Same Facility ☐ Another Facility Name and Phone Number: _____ Begin Date: _____

☐ IOP ☐ Same Facility ☐ Another Facility Name and Phone Number: _____ Begin Date: _____

☐ Outpatient ECT ☐ Same Facility ☐ Another Facility Name and Phone Number: _____ Begin Date: _____

Did the facility share the member's behavioral health treatment with his or her primary care physician? ☐ Yes ☐ No

If the member has any of the following conditions, please check all that apply:

☐ Asthma
☐ Chronic Obstructive Pulmonary Disease
☐ Heart Disease Smoking
☐ Hyperlipidemia
☐ Back Pain
☐ Diabetes
☐ Smokes
☐ Weight Management Issues/Obesity
☐ Hypertension
☐ Pregnant
☐ Migraines

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