Behavioral Health Discharge Summary

Please fax within 24 hours of discharge to WellCare at: 1-877-338-3686

Consider: *The purpose of the discharge review is to show the final disposition of the case and provide enough information to assist case management in follow-up care.*

Member Name:		**Member ID:**	
Authorization Number:		**Phone:**	
Member Address:			
Discharge Date:		**Level of Care at Discharge:**	
Facility:		**Staff Completing Form:**	

If the member is being discharged directly to a residential or extended care program, please specify the type below.

- ☐ **Private Child-Caring Facility (PCC) Residential/Group Home**
- ☐ **Private Child-Caring Facility (PCC) Therapeutic Foster Care**
- ☐ **Residential Treatment Facility (RTF)**
- ☐ **Psychiatric Residential Treatment Facility (PRTF I or II)**
- ☐ **Long-Term Acute Inpatient Hospital Services or Extended Care Unit (ECU)**
- ☐ **Other (please specify):**

Brief discharge summary of treatment received (for follow up by the case management team):

BRIEF SUMMARY OF RECOMMENDATIONS FOR ONGOING TREATMENT

Discharged to where:

Discharge diagnoses:

Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

Does the member understand his/her DX?	☐ Yes ☐ No

DISCHARGE MEDICATION (PSYCHIATRIC AND MEDICAL)

Medication:	Dose:	Schedule:	Supply/Quantity Given at Discharge:	RX Provided:	If RX Provided, Quantity:	RX Prior Authorization Required:	Prior Authorization Completed:
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Does the member understand the reason for taking these medications?	☐Yes ☐No

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FOLLOW-UP APPOINTMENTS Please schedule within 7 days of discharge and provide appointment details for all referred services.				
PCP/Other Providers Involved in Treatment:				
Appointment Type:	**Provider Name:**	**Provider Phone:**	**Appointment Date:**	**Appointment Time:**
☐ **Assessment (new to OP services)**				
☐ **Case Management**				
Is the member already enrolled in case management?		☐ **Yes** ☐ **No**	**If yes, date the CM was notified:**	
If no, was the CM referral offered?		☐ **Yes** ☐ **No**	**Accepted?** ☐ **Yes** ☐ **No**	
Is the Release of Information in the chart? ☐ **Yes** ☐ **No**				
Medication Management (for member discharged with psychiatric medications):				
A&D Treatment (for member with substance abuse/ dependence in the past year):				
Medical Condition (for member with a medical condition):				
Other recommended treatment:				
Do you have any concerns about the discharge plan?			☐ **Yes** ☐ **No**	
If yes, explain:				
Was the member involved in the discharge planning?			☐ **Yes** ☐ **No**	
If no, explain:				
Was a copy of the discharge plan provided to the member?			☐ **Yes** ☐ **No**	
If no, explain:				