Connecticut BHP
Supporting Health and Recovery

HIGHER LEVEL OF CARE DISCHARGE TEMPLATE

ALL FIELDS WITH * ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID): _____

Facility/Provider Name: _____ **Contact # & Ext:** _____

Facility/Provider Service Location: _____

Name of clinician who filled out this form: _____ **Credentials/Title**: _____

Member Name: _____

Medicaid/Consumer ID#: _____ **DOB**: _____ **and/or SSN:** _____

LEVEL OF CARE: ☐ **Inpatient** ☐ **Partial Hospitalization** ☐ **Freestanding Detox** ☐ **Residential Rehab**
☐ **PRTF** ☐ **Inpatient Detox** ☐ **SFIT** ☐ **Adult Group Home**

QUESTIONS:

1. *** Actual Discharge date** (EX: 09/01/2017)**:** _____
2. ***Behavioral Diagnoses (*Primary is required)**
   ***Diagnosis Code:** _____ ***Description** _____
   ***Diagnostic Category:** _____
   Diagnosis Code: _____ **Description** _____
   Diagnostic Category: _____
3. ***Primary Medical Diagnoses *(Primary is required or indicate "None" or "Unknown")***
   ***Diagnosis Code:** _____ ***Description** _____
   ***Diagnostic Category:** _____
4. ***Social Elements Impacting Diagnoses *(Required - Check all that apply)***
   ☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)
   ☐ Occupational problems ☐ Other psychosocial and environmental problems _____
   ☐ Problems with access to health care services ☐ Homelessness
   ☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group
   ☐ Problems related to social environment ☐ Medical disabilities that impact diagnosis ☐ Unknown
5. **Functional Assessment *(Optional)***
   ☐ CDC- HRQOL ☐ CGAS ☐ FAST ☐ GAF ☐ OMFAQ ☐ SF12 ☐ SF36 ☐ WHO DAS
   ☐ OTHER _____ ASSESSMENT SCORE _____
6. ***Discharge Condition Compared to Admittance** *(Please check appropriate box.)***:**
   ☐ Improved ☐ No Change ☐ Worse ☐ Unknown
7. ***Medication at Discharge with Dosage and Frequency *(Narrative):***
   _____
   _____

CURRENT RISKS (Key):

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

Please circle one of the following for each question below based on Current Risks Key above:

8. ***Member's risk to self?** 0 1 2 3 N/A

Check all that apply: *(*Required if Risk is Moderate or Severe)*

☐ Ideation ☐ Intent ☐ Plan ☐ Means ☐ Current Serious Attempts ☐ Prior Serious Attempts ☐ Prior Gestures

9. ***Member's risk to others?** 0 1 2 3 N/A

Check all that apply: *(*Required if Risk is Moderate or Severe)*

☐ Ideation ☐ Intent ☐ Plan ☐ Means ☐ Current Serious Attempts ☐ Prior Serious Attempts ☐ Prior Gestures

10. CURRENT IMPAIRMENTS

A. *Mood Disturbances (Depression or Mania)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

C.. *Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

B. *Weight Changes Associated with Behavioral Diagnosis
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating:
Weight ☐ Gain ☐ Loss ☐ N/A
Past 3 Mos_____Lbs ☐ N/A
Current Wt_____ Lbs ☐ N/A
Height_____ Ft_____In ☐ N/A

D. *Psychosis / Hallucinations / Delusions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

E. *Medical / Physical Conditions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
☐

F. *Thinking/Cognitive/Memory/Concentration Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

G. *Substance Use / Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating, check all that apply:
☐ Alcohol Illegal ☐ Drugs ☐Prescription Drugs

H. *Impulsive/Reckless/Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

I. *Job/School/Performance Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

J. *Activities of Daily Living Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

K. *Social Functioning/Relationships/Marital/Family Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

L. *Impairments Related to Loss/Trauma
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

M. *Legal
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

For 1, 2 or 3 rating: Check all that apply
☐ Juvenile Justice ☐ Probation ☐ Parole ☐ Other Court

11. *Type of Discharge

☐ Against Medical Advice (AMA) ☐ Planned

12. *Discharge plan in place?

☐ Yes ☐ No

13. *Actual Level of Care/Service Discharged To (Primary)

☐ Detox ☐ Ambulatory Detox ☐ Residential SA Rehab ☐ ASD Services ☐ IICAPS ☐ MDFT ☐ EDT ☐ FFT
☐ FST ☐ MST ☐ IPF ☐ PHP ☐ IOP ☐ Outpatient ☐ GH ☐ Medical ☐ Other Non-Authorized Services
☐ PRTF ☐ RTC ☐ VNA/Home Health ☐ None – Left AMA ☐ None-Left Against Treatment Advice
☐ Medication Assisted Treatment (MAT) ☐ Other (*Please Specify*) _____

14. *PCP Notified? ☐ Yes ☐ No ☐ N/A

15. *Actual Discharge Residence (Primary)

☐ AWOL ☐ Correction Facility ☐ Foster Home ☐ Group Home Non Therapeutic ☐ Group Home Pass

☐ Group Home Therapeutic ☐ Home ☐ Independent Living ☐ Juvenile Detention ☐ Nursing Home/SNF/Assisted Living

☐ PRTF Community ☐ PRTF Solnit ☐ RTC ☐ State Hospital ☐ Supervised/Supportive Housing

☐ Therapeutic Foster Care ☐ Transfer to Alternate Psych or Rehab Facility ☐ Transfer to Medical ☐ Unknown

☐ Other (*Please Specify*): _____

16. ***Is member being discharged from RTC, GH, PRTF?**

☐ Yes ☐ No

17. ***If yes, reason for RTC, GH, or PRTF Discharge?**

☐ Age 18/signed self out ☐ Aged out ☐ AWOL ☐ Court Ordered / Mandated ☐ Fire Setting Risk
☐ Medically Compromised ☐ Needs higher level of care ☐ Parent/Caretaker removed child
☐ Psychiatrically decompensation ☐ Ready for lower level of care ☐ Run away history ☐ Sexually inappropriate
☐ Too aggressive / assault ☐ Too Low functioning

18. **Additional RTC, GH, or PRTF Discharge Information** *(Narrative)*

_____

_____

19. ***Person to Contact for Follow Up:** _____

***Relationship:**

☐ Attorney ☐ Aunt/Uncle ☐ Case Manager ☐ Child ☐ Child-In-Law ☐ Cousin ☐ Executer ☐ Foster Parent
☐ Friend ☐ Grandparent ☐ Guardian ☐ Legal Representative ☐ Niece/Nephew ☐ Other Relation ☐ Parents-In-Law
☐ Parents ☐ Provider/Facility ☐ Self ☐ Sibling ☐ Sibling-In-Law ☐ Sponsor ☐ Spouse ☐ Step-Child
☐ Step-Parent ☐ Step-Sibling ☐ Trustee ☐ Unknown

***Phone #:** _____

20. ***Does the discharge plan involve Member, Guardian and/or Parent participation?**

☐ Yes ☐ No ☐ Unknown

21. ***What CT BHP Servicesare needed?**

☐ ICM ☐ Peer Services ☐ ICM & Peer Services ☐ None

22. **Medical Aftercare** *(Narrative)*

_____

_____

23. **Other Resources/Support Systems to be Utilized** *(Narrative)*

_____

_____

24. ***Primary Aftercare Behavioral Health Provider:** ☐ Arranged ☐ Not Arranged ☐ Do Not Know ☐ Member Refused

If an Aftercare Behavioral Health Provider is arranged, please answer the following:

Provider Name: _____

Provide Phone #: _____ Provider Licensure Level: _____

Provider Address: _____

Scheduled Appointment Date: _____ Scheduled Appointment Time: _____

Member Requests Appointment Reminder: ☐ Yes ☐ No

Type of Appointment: ☐ Mental Health ☐ Substance Use ☐ Medication Management

25. **Secondary Aftercare Behavioral Health Provider** (*Optional*)**:** ☐Arranged ☐Not Arranged ☐Do Not Know ☐Member Refused

If a secondary Aftercare Behavioral Health Provider is arranged, please answer the following:

Provider Name: _____

Provide Phone #: _____ Provider Licensure Level: _____

Provider Address: _____

Scheduled Appointment Date: _____ Scheduled Appointment Time: _____

Member Requests Appointment Reminder: ☐ Yes ☐ No

Type of Appointment: ☐ Mental Health ☐ Substance Use ☐ Medication Management

26. *Aftercare Prescribing Physician: ☐ Arranged ☐ Not Arranged ☐ Do Not Know ☐ Member Refused

If an Aftercare Prescribing Physician is arranged, please answer the following:

Provider Name: _____

Provide Phone #: _____

Type of Prescriber: ☐ Behavioral Health MD ☐ Clinical Nurse Specialist ☐ Primary Care Physician – MD

☐ Psychiatrist ☐ Other *(Please specify):* _____

Scheduled Appointment Date:_____Scheduled Appointment Time:_____

Member Requests Appointment Reminder: ☐ Yes ☐ No

***27.* Medical Care Physician** *(Optional)*

Provider Name: _____

Provide Phone #: _____

Reason for Medical Physician Involvement: ☐ Co-Morbid Medical Condition ☐ Medication Management

☐ Mental Health or Substance Use Follow Up ☐ Routine Medical Care ☐ Other *(Please specify)*: _____

Scheduled Appointment Date: _____ Scheduled Appointment Time: _____

Member Requests Appointment Reminder: ☐ Yes ☐ No

28. Beacon Health Options Health Alert Preferences:

NOTE: Beacon Health Options Health Alert is a program that will send automated calls to members reminding them about their follow-up appointments. You MUST obtain the member's consent before utilizing this service and should only check "Yes" for *Member Requests Appointment Reminder* in the sections above once this consent is obtained. If member consent was obtained, please complete the fields below to detail how the member would like to receive their alert(s).

***Contact Type** ☐ Self

***First and Last Name** _____

***Phone #** _____

Email Address _____

***Preferred Time of Day for Reminders**

☐ Morning (9am to Noon) ☐ Afternoon (Noon to 5pm) ☐ Evening (5pm to 8pm)

***Time Zone**

☐ Alaska ☐ Atlantic ☐ Central ☐ Eastern ☐ Hawaii ☐ Mountain ☐ Pacific

***Preferred Reminder Type**

☐ Phone ☐ Email