

BEHAVIORAL HEALTH DISCHARGE TRANSITION OF CARE FORM**Behavioral Health Care Coordination**

Complete this form and fax it to MeridianComplete and the member's PCP at the time of discharge.

Member Information

Member Name _____

Member ID _____

D.O.B. _____

Member's Discharge Demographics

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____

Check if any of the following apply upon discharge:

- Homelessness – lacks a fixed, regular and adequate nighttime residence.
- Imminent Risk of Homelessness – will imminently lose primary nighttime residence within 14 days or lacks the resources or support networks needed to obtain other permanent housing.
- High-Risk of Homelessness – has not had a lease, ownership interest or occupancy agreement in permanent housing during the last 60 days or had two or more moves during the preceding 60 days.

Acute Service Provider Information

Admitting Service

Provider _____

Admit Date _____

Discharge Date _____

DSM IV Axis Codes

I. _____

II. _____

III. _____

IV. _____

MCOM MI FORM 12

V. _____ Admit GAF _____ Current GAF

Reason for Admit**BH Status upon Discharge****Significant Medical History****Medical Intervention, if Applicable****Primary Care Provider (PCP) Coordination**

PCP Name _____

PCP Phone # _____

PCP Fax # _____

Date last notified _____

Faxed this form to PCP? Yes No

If no, why? _____

PCP Appointment upon Discharge

Appt. Date _____ Appt. Time _____

BH Appointment (within 7 days of discharge)

Provider Name _____

Provider Phone # _____

Appt. Date _____ Appt. Time _____

BH Appointment (within 30 days of discharge)Provider Name
_____Provider Phone #

Appt. Date _____ Appt. Time _____

Clinic or Support Group Appointment (optional)Agency Name

Appt. Date _____ Appt. Time _____

Discharge Medication

	Name	Dose	Qty.	Date	Meds	Script
1.	_____				<input type="checkbox"/>	<input type="checkbox"/>
2.	_____				<input type="checkbox"/>	<input type="checkbox"/>
3.	_____				<input type="checkbox"/>	<input type="checkbox"/>
4.	_____				<input type="checkbox"/>	<input type="checkbox"/>
5.	_____				<input type="checkbox"/>	<input type="checkbox"/>
6.	_____				<input type="checkbox"/>	<input type="checkbox"/>

Member given copy of discharge plan upon discharge?

 Yes No**Use additional forms if necessary. Please fax to the MeridianComplete Behavioral Health department at 313-202-1268.**