Connecticut BHP
Supporting Health and Recovery

REGISTERED SERVICES DISCHARGE TEMPLATE

ALL FIELDS WITH * ARE REQUIRED

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

Facility/Provider Service Location _____

Member Name _____

Medicaid/Consumer ID# _____ DOB: _____ *AND/OR* SSN: _____

LEVEL OF CARE: ☐ **Intensive Outpatient** ☐ **EDT** ☐ **Outpatient** ☐ **Methadone Maintenance** ☐ **Ambulatory Detoxification**
☐ **Home Based Services** ☐ **IICAPS** ☐ **MDFT** ☐ **MST** ☐ **FFT**

QUESTIONS:

1. *** Actual Discharge date** (EX: 09/01/2010)**:** _____

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:** _____
   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 ☐ 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. ***Type of Discharge** ☐ Planned ☐ Unplanned

8. ***Discharge Reason:**
   ☐ No further treatment indicated ☐ Member dropped out ☐ Medication management follow up only
   ☐ Transfer to more intensive LOC ☐ Referral to outpatient service(s) ☐ Member no longer eligible or moved
   ☐ Other _____

9. ***Discharge plan in place?** ☐ Yes ☐ No

10. ***Medication at Discharge with Dosage and Frequency (Narrative):**
    _____
    _____

CURRENT RISKS (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:

11. ***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

12. ***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

13. Current Impairments

A. *Mood Disturbances (Depression or Mania)
☐ 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

C. *Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 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 Abuse / 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
☐ Juv Jus ☐ Probation ☐ Parole ☐ Other Court

14. Ability to self-administer meds without assistance or supervision: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

15. Ability of family/natural supports to supervise medications: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

16. Notified at discharge:

☐ BH Provider ☐ Medical ASO ☐ PCP ☐ LMHA ☐ N/A

☐ OTHER _____