



## DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form. Fax to 1-844-824-7705

### DISCHARGE CONSULTATION INFORMATION

Member Name \_\_\_\_\_ Member Phone: \_\_\_\_\_  
Member DOB \_\_\_\_\_ Parent / Guardian Name: \_\_\_\_\_  
Member ID # \_\_\_\_\_ Best Time to Reach Member/Parent/Guardian: \_\_\_\_\_  
Member Address \_\_\_\_\_ UM Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ Emergency/Other Contact: \_\_\_\_\_  
Facility Fax Number: \_\_\_\_\_

Outpatient Therapist \_\_\_\_\_ Psychiatrist \_\_\_\_\_  
Outpatient Therapist Phone \_\_\_\_\_ Psychiatrist Phone \_\_\_\_\_  
Date of next appointment \_\_\_\_\_ Date of next appointment \_\_\_\_\_  
Case Manager (if applicable) \_\_\_\_\_ Does the member have medication to last until this follow-up? ☐ Yes ☐ No  
Case Manager Phone \_\_\_\_\_

Other follow-up appointments: \_\_\_\_\_  
Name/Type of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of next appointment: \_\_\_\_\_ Did member attend a 513 (Bridge appt. during the discharge process)? ☐ Yes ☐ No  
If yes, name of staff conducting the 513: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of the 513: \_\_\_\_\_ Time of the 513: \_\_\_\_\_

**\*\*\*All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to the health plan to allow for assistance with the appropriate level of follow-up.\*\*\***

Medical Provider/PCP \_\_\_\_\_ Phone \_\_\_\_\_

My signature below certifies that I have agreed to release the information contained here to my PCP and behavioral health providers. My consent is voluntary, can be revoked in writing at any time, and will be used to assist with providing referrals, resources and support related to substance abuse treatment.

#### Current ICD Diagnosis

Primary \_\_\_\_\_  
Secondary \_\_\_\_\_  
Tertiary \_\_\_\_\_  
Additional \_\_\_\_\_  
Additional \_\_\_\_\_  
Medication at discharge \_\_\_\_\_  
Discharge Disposition/Where will member be staying after discharge? \_\_\_\_\_

Signature of Facility Staff

Signature of Member/Guardian

Date of Admission/Discharge

Time of Discharge

SUBMIT TO

#### Utilization Management Department

8325 Lenexa Dr., Ste. 410

Lenexa, KS 66214

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Fax: 1-844-824-7705