FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

Behavioral Health Discharge Note
(Behavioral Health Inpatient)

Please fax to **888-796-5521** 24 hours prior to discharge .

Today's date:		
Contact information		
Member name:	Member ID #:	Member date of birth:
Member address:		Member phone number:
Name of facility:		Facility NPI/Provider Number:
Date of admit:	Discharged to home, shelter, etc.:	
Date of discharge:	Discharge address:	
Discharge phone number:	If minor or dependent adult, name and contact information of parent or guardian:	

ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):	
Was this discharge against medical advice (AMA)?	☐ Yes ☐ No
Was discharge information sent to the primary care provider (PCP)/psychiatrist?	☐ Yes ☐ No
Was discharge plan discussed with member?	☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to parent/guardian?	☐ Yes ☐ No

Were any of the following included in the discharge plan? Complete all that apply.	
Community support services Service: Provider name: Address: Phone number: Contact person, if known:	**DAODAS or substance use disorder treatment** Service: Provider name: Address: Phone number: Contact person, if known:
Residential services Provider name: Address: Phone number: Contact person, if known:	**Skilled nursing services** Provider name: Address: Phone number: Contact person, if known:

Behavioral Health Discharge Note

Therapeutic foster care	**Electroconvulsive treatment services (ECT)**
Provider name:	Provider name:
Address:	Address:
Phone number:	Phone number:
Contact person, if known:	Contact person, if known:
Other (mental health therapy, medical management, AA, NA)	**Shelter services**
Provider name:	Provider name:
Address:	Address:
Phone number:	Phone number:
Contact person, if known:	Contact person, if known:

Collaboration of Needs: Please indicate if collaboration is needed with any of the below. Include contact name and phone number.

	Yes	No	Contact information
Child or adult protective agency			
Jail/Prison/Court system			
Juvenile Justice			
Nursing or nursing home facility			
Residential program			
School system			

Discharge medications: Include all medications, including medical.
(Please provide dose, frequency, and condition for which medication is prescribed.)

Are these medications on the formulary or do they require precertification?	☐ Yes ☐ No
Has precertification been received, if needed?	☐ Yes ☐ No

Risk assessment

Was the member stable at discharge (no risk for suicide/homicide/psychosis)? ☐ Yes ☐ No If no, please explain:

Aftercare appointment 1 (must be within seven days)	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? ☐ Yes ☐ No If not, please explain below:	
If any identified barriers to discharge, please explain:	

Aftercare appointment 2	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:

Any other Providers involved in the After Care Plan: Please list below with contact information.	

Form submitted by:	
Phone number of person submitting form:	Date form submitted:

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax, or other electronic transmission.