NOTIFICATION OF HOSPITAL DISCHARGE

Referral Site: please check box(s)

( ) Kept Appt
( ) Failed Appt
( ) Call to re-schedule
( ) Letter sent

Name of Hospital___________________________
Date of Call_________________________________
Name of Person Calling_____________________
Staff Rec. Notification______________________
Call Back Number__________________________

Consumer Information:
Name_____________________________**Social Security**________________**MHID#**______________
Address_____________________________________**Phone**______________________ **Race**________
Sex_________ **Date of Birth**____
Date of Admission_____________________ **Date of Discharge**________________________________
Discharge To/Address_______________________________________**by whom**___________________
Discharge Diagnosis_______________________________________ **DSM code**___________________

Consumer Status: ( ) **Active in Services** ( ) **Inactive** ( ) **Never Active**

Does the consumer have an Alcohol or Drug Related Problem? ( ) **No** ( ) **Yes**
If yes,
explain____
____

Does consumer have a History of Suicidal/Homicidal or High risk Behavior? ( ) **No** ( ) **Yes**
Risk Behavior____

Oral Medications	Directions	Supply

Injection Information

Type of Injection	Amount	Date of last Shot	Next Shot Due

Recommendations from Hospital
____

Follow Up Information
Case Coordinator_________________________________**Date of Appt**_____________**Time**_________
Physician____**Date of Appt**_____________**Time**_________

Comment
Section:____
____
____
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(11-08)