Driscoll HEALTH PLAN
A friend of the family

Behavioral Health Inpatient Extended Stay

I. Identifying Information: Medicaid #: _____ Date: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____

Date of birth: ___/___/___ Age: Sex: Date of Admission: ___/___/___ Time: _____

Facility name: _____ Provider#: _____ Name of Contact Person _____

Commitment type: _____ Effective Dates _____ County _____ Judge _____

Referral source: ( ) Admitting MD ( ) MH professional ( ) DPRS ( ) Other (list): _____

Name of admitting physician: _____

IIA. Current status of primary symptoms that require continued acute hospital care:

(Include: 1. Date of most recent occurrence: 2. Frequency; 3. Duration; 4. Severity)

IIB. Other relevant clinical information, about patient from past 72 hours: _____

(Attach additional pages or documents, as necessary) _____

IIC. Current Psychiatric medications (include total daily dose) Also list Start date and or adjustment date:

IID. Discharge criteria:

1.
2.
3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc

III. Admitting diagnosis (Axis I):

IV. Additional diagnosis (Axis II):

Diagnosis (Axis III):

Diagnosis (Axis IV):

IV. Functional assessment scores (DSM IV): **AXIS V: (GAF)**

VI. After care plan:

Provider or facility:

Signature: Date: