DHP Logo 2020 - High Res

**BH Discharge Summary**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member Information** | | | | | | | | | | | | |
| Date of Admission | Days approved | | Days Denied | | | Auth Number | | | | | Date of Discharge | |
| Member Name (Last, First, MI) | | | | | | | | Date of Birth | | Member ID | | |
| Physical Address (Street, City, State, Zip **No P.O. Boxes**) | | | | | | | | County | | | Phone Number | |
| Parent /Guardian Name if a Minor | | | | | | | Relationship | | | | Alt Number | |
| **Facility Information** | | | | | | | | | | | | |
| Facility Name | | | | | | | | | | | Phone Number | |
| Address (Street, City, State, Zip **No P.O. Boxes**) | | | | | | | | | | | Fax Number | |
| **Follow-up appointments** | | | | | | | | | | | | |
| **7-Day Follow-Up Referral** | | | | | | | | | | | | |
| Provider Name | | | | | | | | | Phone Number | | | |
| Physical Address (Street, City, State, Zip **No P.O. Boxes**) | | | | | | | | | Fax Number | | | |
| **Appointment Date** | | **Time** | | | **Instruction** | | | | | | | |
| **30-Day Follow-Up Referral** | | | | | | | | | | | | |
| Provider Name | | | | | | | | | Phone Number | | | |
| Physical Address (Street, City, State, Zip **No P.O. Boxes**) | | | | | | | | | Fax Number | | | |
| **Appointment Date** | | **Time** | | | **Instruction** | | | | | | | |
| **Please contact Driscoll Health Plan Case Management Department for assistance in coordinating follow-up appointments if needed at:**  **361-694-6951 or toll-free 1-877-222-2759** | | | | | | | | | | | | |
| **Current DSM-IV Diagnosis** | | | | **Medication** | | | | | | **Dosage** | | **Date issued** |
| **Axis I** | | | |  | | | | | |  | |  |
| **Axis II** | | | |  | | | | | |  | |  |
| **Axis III** | | | |  | | | | | |  | |  |
| **Axis IV** | | | |  | | | | | |  | |  |
| **Axis V (current)** | | | |  | | | | | |  | |  |
| **Highest level past year GAF** | | | |  | | | | | |  | |  |
| **Mental status upon Discharge:** | | | | | | | | | | | | |

*4525 Ayers St*

*Corpus Christi, TX 78415*

*Toll-free: 1-877-455-1053 – Fax: 361-653-0432*

*Toll-free Inpatient Fax: 1-833-808-2175*