

 **BH Discharge Summary**

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| **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*