AmeriHealth Caritas Delaware

Substance Use Discharge Note

(Inpatient detoxification, substance use disorder rehabilitation, and halfway house)

Please fax to behavioral health Utilization Management (BH UM) department: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Today's date:

CONTACT INFORMATION

Member name:		
Member ID number:	Member date of birth:	Member phone number:
Member address:		
Name of facility:		
Facility NPI number:	Date of admit:	Date of discharge:
Location discharged to (e.g., home or shelter):		Discharge phone number:
Discharge address:		
If a minor or dependent adult, name and contact information or any other pertinent contact information:		

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 or psychiatrist? ☐ Yes ☐ No
Was the discharge plan discussed with the member? ☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? ☐ Yes ☐ No

COLLABORATION OF NEEDS

Please indicate if collaboration is needed with any of the below, and include contact name and phone number:

Adult protective agency: ☐ Yes ☐ No	Contact information:
Jail, prison, or court system: ☐ Yes ☐ No	Contact information:
Long-term services and supports (waiver programs): ☐ Yes ☐ No	Contact information:
Nursing or nursing home facility: ☐ Yes ☐ No	Contact information:
Residential program: ☐ Yes ☐ No	Contact information:
PROMISE program : ☐ Yes ☐ No	Contact information:
Other : ☐ Yes ☐ No	Contact information:

Substance Use Discharge Note

(Inpatient detoxification, substance use disorder rehabilitation, and halfway house)

LIST DISCHARGE MEDICATIONS (INCLUDE ALL MEDICATIONS).
(Please provide the dose, frequency, and condition for which each medication is prescribed.)

Are these medications on the formulary or do they require precertification? ☐ Yes ☐ No

Has precertification been received if needed? ☐ Yes ☐ No

DESCRIBE RISK ASSESSMENT (if there has been no risk assessment, please explain).

Was the member stable at discharge, with no risk for suicide, homicide, or psychosis? ☐ Yes ☐ No

FOLLOW-UP AND/OR TRANSITION TO A LOWER LEVEL OF CARE

Was the member transitioned to a lower level of care? ☐ Yes ☐ No

If yes, please provide specifics below (e.g., level of care, expected start date, and expected duration of treatment):

If there has been no follow-up or transition, please explain:

ARE ANY OTHER PROVIDERS INVOLVED IN THE AFTERCARE PLAN? If yes, please list below with contact information:

Name of the person submitting form:

Phone number of the person submitting form:

Date form submitted