AFTERCARE PLAN SUMMARY AND DISCHARGE FORM

INSTRUCTIONS

SECTION 1

Patient Name must be entered as follows: last name, first name, middle initial.

State facility must be a State Mental Hospital name or a State Restoration Center name.

Patient's 2 digit PCIS Discharge Code must be indicated.

Discharge Address must consist of a complete mailing address with a zip code.

Telephone number must include area code.

Case number at State facility and at BSU must be entered.

SECTION 2

County implies the name of county at admission and at discharge.

Admission and discharge BSU implies the 3 digit catchment area designation that applies from the PCIS system.

Involuntary Outpatient Commitment must be the 4 digit PCIS commitment code at discharge.

Date of Birth - month, day, year of birth. Use the four digits to specify year of birth.

SECTION 3

At least one must be indicated.

SECTION 4

Must be limited to one choice.

SECTION 5

List all psychotropic and other medications, dosage and frequency. Indicate number of days supply provided to patient at discharge. Precautions should also be listed.

Medical Care Referrals - Indicate if patient has been referred, where referred, telephone number, contact person, date and time of appointment. Any special medical conditions should be listed.

Voc/Soc Rehab/Educational Referrals - Indicate if patient has been referred, where referred, telephone number, contact person, date and time of appointment.

SECTION 6

List Base Service Unit at discharge.

List name of Liaison.

List telephone number including area code.

Indicate date the BSU was notified of discharge

Indicate date of aftercare appointment.

Indicate time of aftercare appointment.

If no appointment was made, explain.

Indicate if there was a meeting with patient prior to discharge and if liaison attended.

Indicate if liaison involved.

SECTION 7

Indicate source of income and amount, if known.

If patient is not a recipient, indicate date of referral, status of application, any action to be taken, contact person and telephone number, including area code.

Indicate Medical Assistance number and plan number for any applicable medical insurance.

AFTERCARE PLAN SUMMARY AND DISCHARGE FORM

1

NAME	STATE FACILITY	PCIS D/C CODE
DISCHARGE ADDRESS		TELEPHONE NUMBER
DISCHARGE DATE	ADMISSION DATE	FACILITY CASE NO.	BSU CASE NO.

2

COMMITMENT

COUNTY	AT ADMISSION	AT DISCHARGE
ADMISSION BSU	DISCHARGE BSU	INVOL. OUTPATIENT COMMITMENT (Specify)
DATE OF BIRTH	SOCIAL SECURITY NO.	DIAGNOSES AT DISCHARGE (Psych. & Med.)
NAME OF RESPONSIBLE RELATIVE		RELATIONSHIP
RELATIVE'S ADDRESS		TELEPHONE NUMBER

3

TYPE OF DISCHARGE

☐ PLANNED ☐ UNPLANNED | ☐ AMA ☐ HOSPITAL RECOMMENDED | ☐ UNAUTHORIZED ABSENCE ☐ TRANSFER OUT | ☐ COURT DISPOSITION ☐ DEATH | ☐ OTHER

4

TYPE OF PLACEMENT

INSTITUTIONAL			COMMUNITY		
☐ COUNTY JAIL	☐ INTERMEDIATE CARE	☐ OTHER STATE FACILITY	☐ CRR	☐ PCH	☐ INDEPENDENT LIVING
☐ STATE CORRECTIONAL	☐ V.A.	☐ OTHER	☐ DOM/FOSTER CARE	☐ RELATIVE/ GUARDIAN	☐ CHILD/ADOLESCENT RESIDENTIAL TAX
☐ SKILLED NURSING	☐ COMMUNITY HOSPITAL		☐ ROOMING HOUSE		

NAME OF CORRECTIONAL FACILITY CONTACT (if applicable)	TELEPHONE NUMBER

5

MEDICATION AT DISCHARGE

NAME	DOSAGE/INSTRUCTIONS	NO. DAYS SUPPLIED

Rx PRECAUTIONS ▶

MEDICAL CARE REFERRALS

☐ NOT NEEDED ☐ REFUSED ☐ REFERRAL NOT MADE | SPECIAL MEDICAL CONDITIONS

AGENCY	TELEPHONE NUMBER

CONTACT PERSON	DATE OF APPOINTMENT	TIME ☐ A.M. ☐ P.M.

VOC./SOC. REHAB./EDUCATIONAL REFERRALS

☐ NOT NEEDED ☐ REFUSED ☐ REFERRAL NOT MADE

AGENCY	TELEPHONE NUMBER

CONTACT PERSON	DATE OF APPOINTMENT	TIME ☐ A.M. ☐ P.M.

6 AFTERCARE - FOLLOWUP

BSU:	LIAISON NAME	TELEPHONE NUMBER

DATE NOTIFIED OF DISCHARGE	DATE OF A/C APPT.	TIME ☐ A.M. ☐ P.M.	NO APPT. MADE - EXPLAIN

LIAISON - INVOLVEMENT

MET WITH PATIENT PRIOR TO DISCHARGE?	ATTENDED PLANNING MEETING?	NOT INVOLVED?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

7 INCOME

☐ CAO ☐ SSI ☐ SS ☐ VA ☐ OTHER ☐ APP. DENIED

RECIPIENT ▶ AMOUNT $	**NON-RECIPIENT ▶** DATE REFERRED	STATUS OF APP.

ACTION NEEDED	
CONTACT PERSON	TELEPHONE NUMBER
HEALTH INSURANCE/M.A.	POLICY NO.

COMMENTS:

☐ **MH ADVANCE DIRECTIVE INFORMATIONAL BROCHURE PROVIDED AT DISCHARGE**

☐ **SIGNED CSP (Dated _____) GIVEN TO CONSUMER UPON DISCHARGE.**

PREPARED BY

DATE COMPLETED

DATE SENT

TELEPHONE NUMBER

(NETWORK)