mhs health wisconsin™

DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form. Fax to 1.866.535.6974

DISCHARGE CONSULTATION INFORMATION

Member Name _____

Member DOB _____

Member ID # _____

Member Address _____

Facility Name: _____

Facility Fax Number: _____

Member Phone: _____

Parent / Guardian Name: _____

Best Time to Reach Member/Parent/Guardian: _____

UM Name: _____

Emergency/Other Contact: _____

Outpatient Therapist _____

Outpatient Therapist Phone _____

Date of next appointment _____

Case Manager (*if applicable*) _____

Case Manager Phone _____

Psychiatrist _____

Psychiatrist Phone _____

Date of next appointment _____

Does the member have medication to last until this follow-up? Yes☐No☐

Other follow-up appointments: _____

Name/Type of Provider: _____ Phone: _____

Date of next appointment: _____

*****All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to the health plan to allow for assistance with the appropriate level of follow-up.*****

Medical Provider/PCP _____ Phone _____

My signature below certifies that I have agreed to release the information contained here to my PCP and behavioral health providers. My consent is voluntary, can be revoked in writing at any time, and will be used to assist with providing referrals, resources and support related to substance abuse treatment.

Current ICD Diagnosis

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Medication at discharge _____

Discharge Disposition/Where will member be staying after discharge? _____

_____
Signature of Facility Staff

_____
Signature of Member/Guardian

_____
Date of Admission/Discharge

_____
Time of Discharge

SUBMIT TO
Utilization Management Department
Phone: 1.800.589.3186
Fax: 1.866.535.6974