Discharge Consultation Documentation

Please Fax to 866-535-6974

Member Name: _____ DOB: _____

Member ID#: _____ Parent/Guardian: _____

Address: _____

Phone: _____ Best time to reach member/parent/guardian: _____

Emergency and/or Additional Point of Contact: _____ Phone: _____

Outpatient Therapist: _____ Phone: _____

Date of next appointment: _____

Case Manager (if applicable): _____ Phone: _____

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: _____

Did member attend a 510 (Bridge) appt. during the discharge process? ☐ Yes ☐ No
If yes, name of staff conducting the 510: _____
Phone: _____
Date of the 510: _____ Time of the 510: _____

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 Ambetter to allow for assistance with the appropriate level of follow-up.

Medical Provider/PCP: _____ Phone: _____

Discharge Diagnosis:
I. _____ IV. _____
II. _____ V. _____
III. _____

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