

BEHAVIORAL HEALTH DISCHARGE TRANSITION OF CARE FORM
Behavioral Health Care Coordination

Complete this form and fax it to MeridianHealth (Meridian) and the member's PCP at the time of discharge.

Member Information

 Member Name _____
 Member ID _____
 D.O.B. _____

Acute Service Provider Information

 Admitting Service Provider _____
 Admit Date _____ Discharge Date _____

Member's Discharge Demographics

 Address _____
 City _____ State _____ Zip _____
 Phone Number(s) _____

DSM-5 Diagnosis

ICD-10 Code	Diagnosis

Check if any of the following apply upon discharge:

- Homelessness – lacks a fixed, regular and adequate nighttime residence.
- Imminent Risk of Homelessness – will imminently lose primary nighttime residence within 14 days or lacks the resources or support networks needed to obtain other permanent housing.
- High-Risk of Homelessness – has not had a lease, ownership interest or occupancy agreement in permanent housing during the last 60 days or had two or more moves during the preceding 60 days.

Reason for Admit _____

BH Status upon Discharge _____

Significant Medical History _____

Medical Intervention, if Applicable _____

BH Appointment (within 30 days of discharge)

 Provider Name _____
 Provider Phone # _____
 Appt. Date _____ Appt. Time _____

Primary Care Provider (PCP) Coordination

 PCP Name _____
 PCP Phone # _____
 PCP Fax # _____
 Date last notified _____
 Faxed this form to PCP? Yes No
 If no, why? _____

Clinic or Support Group Appointment (optional)

 Agency Name _____
 Appt. Date _____ Appt. Time _____

PCP Appointment upon Discharge

Appt. Date _____ Appt. Time _____

BH Appointment (within 7 days of discharge)

 Provider Name _____
 Provider Phone # _____
 Appt. Date _____ Appt. Time _____

Discharge Medication

	Name	Dose	Qty.	Date	Meds	Script
1.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
5.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
6.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Use additional forms if necessary. Please fax to MeridianHealth's Behavioral Health department at 313-309-8588.