PLEASE PRINT
Attach additional pages if more space is needed.

Attachment 3e

HealthChoice/DHMH Discharge Summary

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____ am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan.This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___ F___	4a. Client's MCO Number 4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		

7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number

9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam

13a. Client Pregnant? Yes____ No____ 13b. If Yes, Due Date _____	14. OB/GYN:_____ a. Pre Natal Appt Scheduled:_____ b. Pre Natal Appt Completed:_____ c. OB/GYN Knows of Pregnancy? Yes____ No____

15. Date Present Treatment Began (mo, day, yr)	16. Date Treatment Terminated (mo, day, yr)

17. Diagnosis (Please complete all axes.) Use DSMIV Codes

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V (GAF) at:
Admission
Discharge

18. Initial Reason for Seeking Treatment

19. List All Medications (including Methadone/LAAM)

Type	Dosage	Start Date	Response

PLEASE PRINT
Attach additional pages if more space is needed.

Attachment 3e

HealthChoice/DHMH
Discharge Summary

20. Stages of Treatment Completed
- Ambulatory Detox
- Individual or group therapy
- Intensive Outpatient Therapy
- Partial Hospitalization
- ICF-A
- Methadone Maintenance
- Inpatient Detox in inpatient setting
- Inpatient Detox in a rehabilitation or ICF-A facility

*AMERICAID members with group number M1JH are assigned to the Johns Hopkins Medical Services Corp. For notification call 410-424-4657.
* FreeState members with a region # of 810 in the top left corner of the ID card are patients of a Total HealthCare site. For notification, call 410-361-8100.

21. Urine Drug Screens/Breathalyzer Results Last 6 Tests

Positive Dates	Drug/Alcohol Screens	**Negative** Dates

22. Reason for Discharge
- Completed Treatment, No Substance Problem – No Substance Use_____
- Completed Treatment, No Substance Problem – Some Substance Use_____
- Completed Treatment Plan Referred_____
- Did Not Complete Treatment Referred_____
- Non-Compliance – Administrative Discharge_____
- Client Left Before Completing_____
- Incarcerated_____
- Death_____
- Change in Service Within Episode_____

23. After Care Plan- Check all that apply
- No Referral_____
- To Methadone_____
- To Intensive OP_____
- To Other OP_____
- To Detox_____
- To Intermediate House _____
- To Halfway House/Group Home_____
- To Long Term Care_____
- To Other Residential Substance Abuse Program_____
- To Self-Help Programs (AA, NA)_____
- To Comm Mental Heatlh_____
- To General Hospital_____
- To Psychiatric Hospital_____
- Other_____

PLEASE PRINT
Attach additional pages if more space is needed.

Attachment 3e

HealthChoice/DHMH
Discharge Summary

24. Notification to Primary Care Physician? No _____ Yes_____ Date_____
25. Substance Abuse Provider's Criteria for Re-Admission