

HealthChoice and PAC Substance Abuse Discharge Summary

Please complete all sections. 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. Level I: Traditional Outpatient Level II.1: Intensive Outpatient OMT: Methadone Maintenance

2. MCO Name: _____ Date Submitted to MCO: ____/____/____ Time: _____

3. Client's Name: (Last) _____, (First) _____

4. Client's Date of Birth: ____/____/____ 5. Client's Gender: M: ____ F: ____ 6. Client's MA #: _____ 7. Client's MCO # (if different) : _____

8. Other Insurer Group # (if applicable) : _____ 9. Client's Complete Address: _____ 10. Client's Phone Number: (____) _____

11. Treatment Facility Name: _____ 12. Facility MA #: _____ 13. Facility Tax ID #: _____
Address: _____
Phone: (____) _____ Fax: (____) _____

14. Primary Care Physician (if known) : _____ 15. Discharge Date from this Facility: ____/____/____ 16. Client Pregnant?: Y N
If yes, Due Date (if known) : _____
Scheduled to receive prenatal care? Y N

17. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V (GAF):

Admission:

Discharge:

18. List ALL Medications at time of discharge prescribed by the substance abuse treatment provider (including Methadone/LAAM). Attach additional pages if necessary.

Name of Medication	Dosage	Frequency	Adherence (e.g., Yes, No, Unknown)

19. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
1.			
2.			
3.			
4.			
5.			
6.			

