

## HealthChoice Substance Use Disorder 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 participant.

1.  Level I: Traditional Outpatient       Level II.1: Intensive Outpatient       OMT: Methadone Maintenance

2. MCO Name: \_\_\_\_\_ Date Submitted to MCO: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

3. Participant's Name: (Last) \_\_\_\_\_, (First) \_\_\_\_\_

4. Participant's Date of Birth: \_\_\_\_\_ 5. Participant's Gender: M: \_\_\_\_\_ F: \_\_\_\_\_ 6. Participant's MA #: \_\_\_\_\_ 7. Participant's MCO # (if different) : \_\_\_\_\_

8. Other Insurer Group # (if applicable) : \_\_\_\_\_ 9. Participant's Complete Address: \_\_\_\_\_ 10. Participant'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. Participant 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.			

**20. 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 \_\_\_\_\_
- Participant Left Before Completing \_\_\_\_\_
- Incarcerated \_\_\_\_\_
- Death \_\_\_\_\_
- Change in Service Within Episode \_\_\_\_\_

**21. After Care Plan – Check all that apply**

√	After Care Services	Name of Program	Contact Name and Telephone #
	No Referral		
	To Methadone		
	To Intensive Outpatient (IOP)		
	To Other Outpatient (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 Community Mental Health		
	To General Hospital		
	To Psychiatric Hospital		
	Suboxone		
	Other Community Services		
	Other:		

**22. Notification to Primary Care Physician?** No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_

**23. Summary of Treatment (optional) :**

**24. Treatment Clinician's Name:**

Printed \_\_\_\_\_

Clinician Signature \_\_\_\_\_

Credentials \_\_\_\_\_

Date \_\_\_\_\_

Treatment Clinician's Email Address \_\_\_\_\_

Treatment Clinician's Phone Number \_\_\_\_\_