

Family Focused/Solution Based Services Discharge Review

IDENTIFYING INFORMATION		
Child's Name:	Date of Birth/Age:	MA #:
		SSN:
Provider Name:		
DISCHARGE REVIEW:		
Actual Discharge Date		
Primary Discharge Diagnosis		
Discharge GAF		
Discharge Condition <input type="checkbox"/> Improved <input type="checkbox"/> Same <input type="checkbox"/> Worse		
CURRENT RISK – Check all that apply		
Member's Risk to Self: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	Member's Risk to Others: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	

CURRENT IMPAIRMENTS – Key:		
<input checked="" type="checkbox"/> 0 (None) <input checked="" type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input checked="" type="checkbox"/> 2 Moderate or Moderately Incapacitating <input checked="" type="checkbox"/> 3 (Severe or Severely Incapacitating) <input checked="" type="checkbox"/> NA (Not Assessed)		
Mood Disturbances (Depression or Mania)	Weight Loss Associated with an Eating Disorder	Anxiety
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Medical/Physical Conditions	Psychosis/Hallucinations/Delusions	Substance Abuse/Dependence
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Thinking/Cognition/Memory/Concentration Problems	Job/School Performance Problems	Impulsive/Reckless/Aggressive Behavior
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Social Functioning Relationships/Marital/Family Problems	Activities of Daily Living Problems	Legal
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

AFTERCARE FOLLOW-UP APPOINTMENTS			
	Date and Time	# of days until 1 st appt.	Within Timeframe-(7 days)
Behavioral Health Provider/Level of Care:			
Behavioral Health Provider/Level of Care:			
Behavioral Health Provider/Level of Care:			

FAX COMPLETED FORM TO: 724-744-6522