***Complete this form and fax to 1-888-656-2586 within one day of the member’s discharge.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Today’s Date: | Discharge Date: | | Person Completing Form: | |
| Facility Name: | | MIS #: | | Facility Phone Number: |

**Member Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Member’s Name: | | Date of Birth: | |
| Street: | | | City: |
| ZIP Code: | Phone Number: | | Medicaid Number: |

**Address Member Discharged to:**

|  |
| --- |
| Address Member Discharged to:  Best Phone Number to Reach Member: |

***If member is a minor, include legal guardian name and contact number:***

|  |  |
| --- | --- |
| Guardian (1) Name: | Guardian Phone Number: |
| Guardian (2) Name: | Guardian Phone Number: |

**Discharge Summary**

|  |  |
| --- | --- |
| Discharge Status: | Discharge Disposition/Type: |
| *If other, describe:* | |
| Prognosis: | Discharge Plan Discussed? |

**Discharge Diagnosis** *(Enter ICD-10 code and description*)

|  |  |
| --- | --- |
| Code: | Description: |
| Code: | Description: |
| Code: | Description: |

**Medications at Discharge**

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

**Discharge Follow-up Appointment** (Must be within seven calendar days)

|  |  |  |
| --- | --- | --- |
| Date of Follow-up Appointment: | | Level of Care: |
| Provider Name: | | |
| Provider Address: | | |
| City: | State: | ZIP Code: |
| Provider Phone Number: | | |

|  |  |  |
| --- | --- | --- |
| Date of Follow-up Appointment: | | Level of Care: |
| Provider Name: | | |
| Provider Address: | | |
| City: | State: | ZIP Code: |
| Provider Phone Number: | | |

**Barriers to treatment** (e.g., medication adherence, housing, transportation, support system)

|  |
| --- |
|  |