

AFTERCARE PLAN SUMMARY AND DISCHARGE FORM

INSTRUCTIONS

SECTION 1

Patient Name must be entered as follows: last name, first name, middle initial.

State facility must be a State Mental Hospital name or a State Restoration Center name.

Patient's 2 digit PCIS Discharge Code must be indicated.

Discharge Address must consist of a complete mailing address with a zip code.

Telephone number must include area code.

Case number at State facility and at BSU must be entered.

SECTION 2

County implies the name of county at admission and at discharge.

Admission and discharge BSU implies the 3 digit catchment area designation that applies from the PCIS system.

Involuntary Outpatient Commitment must be the 4 digit PCIS commitment code at discharge.

Date of Birth - month, day, year of birth. Use the four digits to specify year of birth.

SECTION 3

At least one must be indicated.

SECTION 4

Must be limited to one choice.

SECTION 5

List all psychotropic and other medications, dosage and frequency. Indicate number of days supply provided to patient at discharge. Precautions should also be listed.

Medical Care Referrals - Indicate if patient has been referred, where referred, telephone number, contact person, date and time of appointment. Any special medical conditions should be listed.

Voc/Soc Rehab/Educational Referrals - Indicate if patient has been referred, where referred, telephone number, contact person, date and time of appointment.

SECTION 6

List Base Service Unit at discharge.	Indicate time of aftercare appointment.
List name of Liaison.	If no appointment was made, explain.
List telephone number including area code.	Indicate if there was a meeting with patient prior to discharge and if liaison attended.
Indicate date the BSU was notified of discharge	
Indicate date of aftercare appointment.	Indicate if liaison involved.

SECTION 7

Indicate source of income and amount, if known.

If patient is not a recipient, indicate date of referral, status of application, any action to be taken, contact person and telephone number, including area code.

Indicate Medical Assistance number and plan number for any applicable medical insurance.

AFTERCARE PLAN SUMMARY AND DISCHARGE FORM

NAME	STATE FACILITY	PCIS D/C CODE
DISCHARGE ADDRESS		TELEPHONE NUMBER
DISCHARGE DATE	ADMISSION DATE	FACILITY CASE NO.
BSU CASE NO.		

1

COMMITMENT			
COUNTY	AT ADMISSION	AT DISCHARGE	
ADMISSION BSU	DISCHARGE BSU	INVOL. OUTPATIENT COMMITMENT (Specify)	
DATE OF BIRTH	SOCIAL SECURITY NO.	DIAGNOSES AT DISCHARGE (Psych. & Med.)	
NAME OF RESPONSIBLE RELATIVE			RELATIONSHIP
RELATIVE'S ADDRESS			TELEPHONE NUMBER

2

TYPE OF DISCHARGE				
<input type="checkbox"/> PLANNED	<input type="checkbox"/> AMA	<input type="checkbox"/> UNAUTHORIZED ABSENCE	<input type="checkbox"/> COURT DISPOSITION	<input type="checkbox"/> OTHER
<input type="checkbox"/> UNPLANNED	<input type="checkbox"/> HOSPITAL RECOMMENDED	<input type="checkbox"/> TRANSFER OUT	<input type="checkbox"/> DEATH	

3

TYPE OF PLACEMENT					
INSTITUTIONAL			COMMUNITY		
<input type="checkbox"/> COUNTY JAIL	<input type="checkbox"/> INTERMEDIATE CARE	<input type="checkbox"/> OTHER STATE FACILITY	<input type="checkbox"/> CRR	<input type="checkbox"/> PCH	<input type="checkbox"/> INDEPENDENT LIVING
<input type="checkbox"/> STATE CORRECTIONAL	<input type="checkbox"/> V.A.	<input type="checkbox"/> OTHER	<input type="checkbox"/> DOM/FOSTER CARE	<input type="checkbox"/> RELATIVE/GUARDIAN	<input type="checkbox"/> CHILD/ADOLESCENT RESIDENTIAL TAX
<input type="checkbox"/> SKILLED NURSING	<input type="checkbox"/> COMMUNITY HOSPITAL		<input type="checkbox"/> ROOMING HOUSE		
NAME OF CORRECTIONAL FACILITY CONTACT (if applicable)					TELEPHONE NUMBER

4

MEDICATION AT DISCHARGE		
NAME	DOSAGE/INSTRUCTIONS	NO. DAYS SUPPLIED
Rx PRECAUTIONS ▶		

5

MEDICAL CARE REFERRALS			
<input type="checkbox"/> NOT NEEDED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFERRAL NOT MADE	SPECIAL MEDICAL CONDITIONS
AGENCY			TELEPHONE NUMBER
CONTACT PERSON		DATE OF APPOINTMENT	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

VOC./SOC. REHAB./EDUCATIONAL REFERRALS			
<input type="checkbox"/> NOT NEEDED	<input type="checkbox"/> REFUSED	<input type="checkbox"/> REFERRAL NOT MADE	
AGENCY			TELEPHONE NUMBER
CONTACT PERSON		DATE OF APPOINTMENT	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

AFTERCARE - FOLLOWUP

6

BSU:		LIAISON NAME			TELEPHONE NUMBER
DATE NOTIFIED OF DISCHARGE	DATE OF A/C APPT.	TIME	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	NO APPT. MADE - EXPLAIN	

LIAISON - INVOLVEMENT

MET WITH PATIENT PRIOR TO DISCHARGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ATTENDED PLANNING MEETING? <input type="checkbox"/> YES <input type="checkbox"/> NO	NOT INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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INCOME

7

<input type="checkbox"/> CAO	<input type="checkbox"/> SSI	<input type="checkbox"/> SS	<input type="checkbox"/> VA	<input type="checkbox"/> OTHER	<input type="checkbox"/> APP. DENIED
RECIPIENT ▶	AMOUNT \$	NON-RECIPIENT ▶	DATE REFERRED	STATUS OF APP.	
ACTION NEEDED					
CONTACT PERSON				TELEPHONE NUMBER	
HEALTH INSURANCE/M.A.				POLICY NO.	

COMMENTS:

MH ADVANCE DIRECTIVE INFORMATIONAL BROCHURE PROVIDED AT DISCHARGE

PREPARED BY

DATE COMPLETED

DATE SENT

TELEPHONE NUMBER

(NETWORK)