



OUTPATIENT DISCHARGE FORM

Please complete and submit this Discharge Form for your ValueOptions patient as soon as you confirm a Discharge Date. For example, if this is an unplanned, patient-directed discharge, submit this form as soon as you are aware of the fact that your patient has discontinued using your services.

Actual Discharge Date: ____/____/____

Type of Service: Mental Health Substance Abuse

Patient Name: _____

Date of Birth: _____ Age: _____ M F

Address (City/State only): _____ Tel #: _____

Patient's Insurance ID#: _____

Patient's Employer/Benefit Plan: _____

Provider Name: _____ License: _____

Provider Program/Clinic (if applicable): _____

VO Provider # (if known): _____

Service Address: _____ Tel #: _____

City/State/Zip: _____

Licensure level (type of license): _____

Are you independently licensed to provide services in the State where you are treating this patient? Yes No

ID #: _____ Check Which: SSN Tax ID NPI

Primary Discharge DSM-IV Diagnosis: _____

Discharge Condition: Improved No Change Worse Unknown

Type of Discharge: Planned Unplanned

Discharge Reasons: (Check all that apply)

- No further treatment indicated/stable
- Chose to disengage at this time
- Medication Management follow-up only
- Required more intensive services
- Chose other outpatient provider/service
- No longer eligible
- Moved
- Unable to contact
- Other: _____

Current Risk Assessment:

Scale: 0 = none 1 = mild, ideation only
 2 = moderate, ideation with EITHER plan or history of attempts
 3 = severe, ideation AND plan, with either intent or means
 na = not assessed
 (Please select/circle one value for each type of risk)

Patient's risk to self: 0 1 2 3 na With: Ideation Intent Plan Means

Patient's risk to others: 0 1 2 3 na With: Ideation Intent Plan Means

Current Impairments: (Please select/circle one value for each type of impairment)

Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately incapacitating
 3=severe or severely incapacitating na=not assessed

Mood Disturbance (Depression or Mania)	0	1	2	3	na
Anxiety	0	1	2	3	na
Psychosis/Hallucinations/Delusions	0	1	2	3	na
Thinking/Cognition/Memory/Concentration Problems	0	1	2	3	na
Impulsive/Reckless/Aggressive Behavior	0	1	2	3	na
Activities of Daily Living Problems	0	1	2	3	na
Weight Change Associated with a Behavioral Diagnosis	0	1	2	3	na
Medical/Physical Condition	0	1	2	3	na
Substance Abuse/Dependence	0	1	2	3	na
Job/School Performance Problems	0	1	2	3	na
Social/Relationship/Marital/Family Problems	0	1	2	3	na
Legal Problems	0	1	2	3	na

Treating Provider's Signature: _____

Date: _____