OhioHealthy

## Behavioral Health Discharge Summary

| Member's Name / Last, First | Member's ID / Policy # | Date of Birth / Age | Today's Date |
|---|---|---|---|
| | | | |

Facility Name: _____

Attending MD: _____ UM Contact Name: _____

UM Fax Number: _____ UM Contact Phone: _____

Admit Date: Discharge Date:

Psychiatric Discharge Diagnosis Listing: _____

_____

Medical Concerns: _____

_____

Discharge Medications (Include Name, Dose, and Frequency): _____

_____

_____

_____

_____

*** If Decanoate or Invega Sustenna, note the last date medication was received & next date medication is to be administered ***

Discharge Destination Information:

Name of Parent/Guardian if applicable: _____

Destination address at time of discharge: _____

Destination phone number: _____

Follow up appointments: Please provide date/time of the appointment (s), provider's first & last name & the provider's office phone number.

_____

_____

_____

_____

_____

_____

Please submit Discharge Summary to 330-656-2449 or 1-800-385-7085