

**St. Clair County Community Mental Health
Hospital Discharge Form**

***Forward to Customer Service Staff once completed within one working day.

Tel:(810)488-8888 Fax:(810)985-7620

Date:

Hospital Name:			
CMH Case # for Client:		Client Name:	
Hospital Admit Date:		Hospital Discharge Date:	
Hospital Admit Time:		Hospital Discharge Time:	
Insurance:		Date of Birth:	
PARTIAL Days Attended:		PARTIAL Days Absent:	

Disposition:

CMH/Affiliate:				
<input type="checkbox"/> MI	<input type="checkbox"/> DD	<input type="checkbox"/> SUD	<input type="checkbox"/> Adult	<input type="checkbox"/> Child
<input type="checkbox"/> Not Eligible For PIHP (CMH/SUD) Network Service:				
<input type="checkbox"/> Referred Out to Behavioral Health Agency: _____ <input type="checkbox"/> Referred Out to a Community/Non-Behavioral Healthcare Agency <input type="checkbox"/> Referred Out to MHP: _____				
<input type="checkbox"/> Eligible – Applicant Refused Services:				
Reason(s):				
<input type="checkbox"/> Eligible – Referred to CMHSP Service				
<input type="checkbox"/> Eligible – Referred to SUD Service				
<input type="checkbox"/> Expedited SUD Referral				

Follow Up Care Information / Discharge Appointment:

Follow up Appt set with	Date	Time	Contact Person
<input type="checkbox"/> Consumer Requested Outside 7 Day			

****Attending Psychiatrist:** _____

Medications: Dose & Frequency

<input type="checkbox"/> Abilify	<input type="checkbox"/> Fluoxetine	<input type="checkbox"/> Pristiq	<input type="checkbox"/> Wellbutrin
<input type="checkbox"/> Adderall	<input type="checkbox"/> Geodon	<input type="checkbox"/> Prozac	<input type="checkbox"/> Xanax
<input type="checkbox"/> Ambien	<input type="checkbox"/> Haldol	<input type="checkbox"/> Remeron	<input type="checkbox"/> Zyprexa
<input type="checkbox"/> Ativan	<input type="checkbox"/> Inderal	<input type="checkbox"/> Risperdal	<input type="checkbox"/> Zoloft
<input type="checkbox"/> Buspar	<input type="checkbox"/> Invega	<input type="checkbox"/> Ritalin	OTHER
<input type="checkbox"/> Catapres	<input type="checkbox"/> Klonopin	<input type="checkbox"/> Seroquel	<input type="checkbox"/>
<input type="checkbox"/> Celexa	<input type="checkbox"/> Lamictal	<input type="checkbox"/> Sertraline	<input type="checkbox"/>
<input type="checkbox"/> Clozaril	<input type="checkbox"/> Lexapro	<input type="checkbox"/> Tegretol	<input type="checkbox"/>
<input type="checkbox"/> Cogentin	<input type="checkbox"/> Lithium	<input type="checkbox"/> Topomax	<input type="checkbox"/>
<input type="checkbox"/> Concerta	<input type="checkbox"/> Luvox	<input type="checkbox"/> Trazodone	<input type="checkbox"/>
<input type="checkbox"/> Cymbalta	<input type="checkbox"/> Metadate	<input type="checkbox"/> Trileptal	<input type="checkbox"/>
<input type="checkbox"/> Depakote	<input type="checkbox"/> Neurontin	<input type="checkbox"/> Valium	<input type="checkbox"/>
<input type="checkbox"/> Desyrel	<input type="checkbox"/> Paxil	<input type="checkbox"/> Vistaril	<input type="checkbox"/>
<input type="checkbox"/> Effexor	<input type="checkbox"/> Prolixin	<input type="checkbox"/> Vyvanse	<input type="checkbox"/>