

# Substance Abuse Discharge Note

(Medical Detoxification and SUD Rehabilitation  
including DAODAS Facilities)

Please fax to **888-796-5521** 24 hours prior to discharge.

Today's date:	
<b>Contact information</b>	
Member name:	Member ID #:
Member date of birth:	
Referral source:	
Member phone number:	
Name of facility:	
Facility NPI/Provider Number:	
Date of admit:	Discharged to home, shelter, etc.:
Date of discharge:	Discharge address:
Discharge phone number:	If minor or dependent adult, name and contact information of parent or guardian:
<b>ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):</b>	
Was this discharge against medical advice (AMA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was discharge information sent to the primary care provider (PCP)/psychiatrist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was discharge plan discussed with member?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If required for a minor or dependent adult: Was informed consent for psychotherapeutic medication completed and given to parent/guardian? Also applicable for adults who have legal guardians.	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Please complete ASAM rating at time of discharge</b>	
Dimension 1 acute intoxication and or/withdrawal potential:	
Explain:	
Dimension 2 biomedical conditions and complications:	
Explain:	
Dimension 3 emotional, behavioral, or cognitive conditions and complications:	
Explain:	

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Dimension 4 readiness to change:
Explain:
Dimension 5 relapse, continued use, or continued problem potential:
Explain:
Dimension 6 recovery environment:
Explain:
Was member transitioned to lower level of care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide specifics below, i.e. level of care, expected start date, and expected duration of treatment:
If no, please explain:

**Discharge medications: Include all medications, including medical.**  
(Please provide dose, frequency, and condition for which medication is prescribed.)

Are these medications on the formulary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer to the above is "no," has precertification been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Risk assessment**

Was the member stable at discharge (no risk for suicide/homicide/psychosis)?  Yes  No If no, please explain:

**Aftercare appointment 1**

Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? <input type="checkbox"/> Yes <input type="checkbox"/> No If no aftercare appointment is scheduled within seven calendar days, please explain why below:	

**Aftercare appointment 2**

Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:

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**Any other Providers involved in the After Care Plan:** Please list below with contact information.

Form submitted by:	
Phone number of person submitting form:	Date form submitted:

**Important Note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax, or other electronic transmission.