FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

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:		
Contact information		
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:

ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):	
Was this discharge against medical advice (AMA)?	☐ Yes ☐ No
Was discharge information sent to the primary care provider (PCP)/psychiatrist?	☐ Yes ☐ No
Was discharge plan discussed with member?	☐ Yes ☐ 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.	☐ Yes ☐ No

Please complete ASAM rating at time of discharge
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:

Substance Abuse Discharge Note

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? ☐ Yes ☐ 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?	☐ Yes ☐ No
If the answer to the above is "no," has precertification been received?	☐ Yes ☐ 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? ☐ Yes ☐ 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:

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.