CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH SERVICES

CLIENT NAME/MRN

MENTAL HEALTH DISCHARGE SUMMARY/BILLING FORM

DATE: _____ RU#: _____ CODE ACTIVITY: __315 PD __571 CMPD __364 MD PD __540 NonBill MHS

STAFF #: _____ HOURS: _____ MINUTES: _____

LOCATION: (please ☑) ☐1 Office ☐ 2 Field ☐ 3 Phone ☐ 4 Home ☐ 5 School

1. **DISCHARGE DIAGNOSIS**: _____

2. **COURSE OF TREATMENT**:

   a. Opening and Closing Date: _____

   b. Referral Source (reason for admission):

   c. Discharge Medications (include dosage and schedule, response, compliance, side effects, adverse labs, and other medication issues):

   d. Allergies: _____

   e. Outcome (treatment highlights, modalities of treatment, goals obtained):

3. **DISCHARGE PLANS:**

   a. Recommendations:

   b. Possible Future Problems:

   c. Referrals Out:

Date: _____ Signature: _____ License/Title: _____

Date: _____ Co-Signature: (if applicable) _____ License/Title: _____

USE REVERSE SIDE FOR ADDITIONAL INFORMATION

MHC022 (Rev. 7/2013)

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Computer Entry Clerical Initials