**Sanilac County Community Mental Health Authority**

**HOSPITAL DISCHARGE PLAN**

Date: Worker Completing:

**IDENTIFYING INFORMATION:**

Name: Case #:

Guardian: Birth Date:

CMH Case Manager: CMH Therapist:

CMH Doctor: Primary Care Physician:

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Peer Support:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applied for Medicaid?: Y or N or NA

**HOSPITAL INFORMATION:**

Hospital:

Assigned Social Worker: Assigned Doctor:

Admission Date: Discharge Date:

Admission Type: Court Order Length:

**TREATMENT/DISCHARGE INFORMATION:**

Discharge Criteria: □ Psychiatric/Mood Stability □ No Longer SI/HI □ Decrease in Depression

 □ Decrease in Anxiety □ Increase in Healthy Coping Skills

 □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Discharge Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Injection Name/Dose/Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Supply at Discharge: □ 30 Day Script □ 15 Day Script □ 7 Day Script

 □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**COMMUNITY INFORMATION:**

Transportation Arrangement:

After Care Living Arrangement: □ Independent Living □ AFC Placement □ Crisis Bed Placement

 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse Referral? Y or N If Yes, to Where?

Outpatient Services Requested: □ Psychiatric □ SC/CM □ Therapy □ Peer □ Homebased

 □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Individual agree to follow up with CMH outpatient treatment? Y or N or NA

**FOLLOW-UP APPOINTMENT:**

 Date Time Worker & Appointment Purpose

 Date Time Psychiatric Evaluation/Med Review

□ David Ehardt Center □ Children’s Services □ Croswell Office □ Other 217 E. Sanilac 227 E. Sanilac 110 N Howard Suite 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sandusky, MI 48471 Sandusky, MI 48471 Croswell, MI 48422 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (810) 648-0330 (810) 648-0330 (810) 648-0330 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FOR CRISIS INTERVENTION AFTER RELEASE FROM THE HOSPITAL, PLEASE CONTACT YOUR ASSIGNED CMH WORKER OR THERAPIST AT THE FOLLOWING #:*** 810-648-0330

***FOR AFTER-HOURS CRISIS INTERVENTION AFTER RELEASE FROM THE HOSPITAL, PLEASE CONTACT THE CRISIS # AT:*** 1-888-225-4447

 Signature Date

 Staff Signature Date

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Plan Distribution

\_\_\_\_Individual \_\_\_\_Case Manager \_\_\_\_File \_\_\_\_Hosp. Liaison \_\_\_\_CMH Therapist \_\_\_\_Nurse \_\_\_\_CMH Psych. \_\_\_\_Prgm. Supervisor

\_\_\_\_Med. Director \_\_\_\_Intake