MARYLAND BEHAVIORAL HEALTH ADMINISTRATION - AFTERCARE REFERRAL FORM

PART I - BASIC DATA

Name: _____ Name of Facility: _____

Released to address: _____ Date Admitted: ___/___/___ Release Date: ___/___/___

_____ Type (*Circle)*: DIS. OBS. A.L.J. ELOPE VISIT____days

Phone: _____ Conditional Release: Yes ___ No ___

Dis. CSA Jurisdiction: _____ Phone: _____ SS#: _____ Date of Birth: ___/___/___

Name of person living with: _____ Relationship: _____ Phone: _____

Significant other/ guardian: _____ Relationship: _____ Phone: _____

Address: _____

PART II - MEDICAL DATA (to be completed by the treating physician)

Reason for Admission: _____

_____

Treatment Initiated in Hospital: _____

_____

_____

_____

DSM 5 Diagnoses: _____

_____

_____

_____

All Discharge Medications:

Medication	Dose	Route/ Schedule	Indication

Number of days of medication provided upon discharge: _____ days.

Date of last IM: ___/___/___ Next date IM due: ___/___/___

Therapeutic Drug Levels:

Medication	Therapeutic Range	Therapeutic Level	Date Last Drawn

_____ _____ _____

Signature of Physician **Date** **Time**

Name of Physician: _____

Addressograph

Original to Medical Records; Copy to Discharged Individual

(Continued) ***PART II - MEDICAL DATA (to be completed by the treating physician)***

Allergies & Reactions: _____

_____

Number of **Antipsychotic Medications** prescribed: _____

Reason for 2 or more prescribed antipsychotic medications: *(check appropriate box below and explain where applicable)*

☐ Code 01: Hx of minimum of 3 or more failed trials of monotherapy *(list at least 3 meds, dates and reason for failure)*

_____

_____

☐ Code 02: Recommended plan to taper to monotherapy or tapering is in process _____

_____

_____

☐ Code 03: Augmentation of clozapine

Comment: _____

Diet: _____

Active somatic problems requiring continued attention:_____

_____

_____

_____

TST (Tuberculin Skin Test) Date ____/____/____ Results _____ N/A _____

Please see page 7 (or attached Addendum) for Physician Assessment of Risk to Self or Others.

_____ _____ _____

Signature of Physician **Date** **Time**

Name of Physician: _____

Addressograph

PART III - DISCHARGE CODES

PRIMARY REFERRAL AT DISCHARGE

Check one of the following categories of primary referral at discharge:

- ☐ 21 - Psychiatric hospital (not accredited as LTC)
- ☐ 22 - Acute care hospital (inpatient)
- ☐ 23 - Community mental health center
- ☐ 24 - Other clinics (hospital based clinic, free-standing provider based federally qualified health center, other rehab. facility, comprehensive outpatient rehab. facility)
- ☐ 25 - Justice System (police, court, correction agency)
- ☐ 26 - Home care or self care: Non-health facility or clinic (physician's office, outpatient provider not associated with clinic or hospital, residential service not associated with clinic or hospital, human service agency)
- ☐ 27 - Hospice - home
- ☐ 28 - Hospice - medical facility
- ☐ 29 - Skilled Nursing Facility (Medicare)
- ☐ 30 - Intermediate Care Facility (also includes nursing facility neither Medicaid nor Medicare, state designated Assisted Living Facility)
- ☐ 31 - Cancer Center or Children's Hospital
- ☐ 32 - Within Hospital Medicare Swing Bed
- ☐ 33 - Home under care of organized home health service organization in anticipation of covered skills care
- ☐ 34 - Inpatient Rehabilitation Facility or distinct part unit of facility (medical)
- ☐ 35 - Long Term Care Hospital (Medicare)
- ☐ 36 - Nursing Facility (Medicaid, not Medicare)
- ☐ 37 - Critical Access Hospital
- ☐ 38 - Federal Health Care Facility (inpatient, residential, outpatient)
- ☐ 39 - Other health care facility not elsewhere defined on list
- ☐ 40 - No aftercare planned
- ☐ 41 - Refused aftercare
- ☐ 42 - Refused to sign release of information to next provider

DISCHARGE CLINICAL STATUS

Check one of the following categories of discharge:

- ☐ 01 - Completed inpatient mental health or substance use treatment
- ☐ 03 - Released by courts
- ☐ 04 - Left against medical advice ("AMA")
- ☐ 05 - Eloped or failed to return from leave
- ☐ 06 - Death
- ☐ 07 - Noncompliance with treatment and/or policies
- ☐ 11 - Extended placement
- ☐ 12 - Client choice
- ☐ 13 - Discharge/ Transfer to any inpatient provider

REASON AFTERCARE APPOINTMENT NOT SCHEDULED

If no aftercare appointment was scheduled, check one of the following reasons:

- ☐ 01 - Client will make appointment
- ☐ 02 - Provider will make appointment
- ☐ 03 - Other
- ☐ 09 - Unknown

Health Information Services Only (Medical Records)

Aftercare form sent to Primary Provider:
Date sent: ___/___/___ Initials: _____

Aftercare form sent to all other initialed providers:
Date sent: ___/___/___ Initials: _____

Release summary sent to Primary Provider:
Date sent: ___/___/___ Initials: _____

Addressograph

PART IV - REFERRALS FOR CONTINUING TREATMENT & SUPPORTIVE RESOURCES

Individual enters initials below

____ Mental Health Treatment **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Somatic/Dental **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Drug/Alcohol Services **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Residential **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Day/Psychiatric Rehabilitation Program **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Case Management **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Vocational/Educational **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

In case of mental health crisis, contact:

Provider: _____

Phone number: _____

Additional information: _____

_____

_____

_____

Addressograph

(Continued) ***PART IV - REFERRALS FOR CONTINUING TREATMENT & SUPPORTIVE RESOURCES***

Individual enters initials below

____ Legal Services (e.g., atty, Prob. Off., CFAP) **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Social Security Administration **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

____ Other **Appt. Date/Time** **Recommendations**

Service Provider: _____ _____ _____

Address: _____

Contact Person: _____ Phone: _____

PART V - ENTITLEMENTS & IDENTIFICATION

(Enter "A" for Active, "P" for Pending, or "NA" for Non-Applicable)

Income/ Assets: SSDI _____ SSI _____ VA _____ Other _____

If Representative Payee for Entitlements, Name/ Address/Phone _____

Medical Coverage: MA _____ Medicare _____ VA _____ Private _____ None _____ Other _____

Medicare Part D: _____ Additional medical coverage: _____

Name of Policy Holder: _____ Policy name & number: _____

Plan for individual to obtain filled prescriptions *(include source of funds)* _____

If application pending, location of office at which applied _____ Phone: _____

Identification: Birth Certificate: _____ Social Security Card _____ MVA Photo Identification: _____

Immigration Status Card: _____ Other Identification: _____

PART VI - ADVANCE DIRECTIVES FOR MENTAL HEALTH

Individual was advised of Advanced Directives for Mental Health prior to release: Yes ____ No ____

Individual requested to complete Advance Directives for Mental Health: Yes ____ No ____

Individual completed Advance Directives for Mental Health: Yes ___ No ____ If "yes", attached? Yes ____ No ____

If "no", referred to provider for completion of Advanced Directives for Mental Health: Yes ____ No ____

Aftercare Codes:

☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9

Addressograph

PART VII - OTHER AFTERCARE INFORMATION

Hospital Treating Physician: _____ Phone: _____

Hospital Social Worker/Case Manager: _____ Phone: _____

Hospital Somatic Physician: _____ Phone: _____

Social/Family: _____

_____

Additional Discharge Information: _____

_____

Key issues in maintaining individual in community _____

_____

_____

_____

Person(s) in community agencies, family or significant others involved in the development of this plan (not listed in Parts IV &V):

Agency or Name(s) of Person(s)	Phone Number(s)
_____	_____
_____	_____

PART VIII - CONSENT FOR RELEASE OF INFORMATION

With individual's written consent _____*(individual enters initials),* person notified of individual's release: Yes ____ No ____

If "yes", the name and relationship of person notified and their response to the plan; if "no", why the person was **not** notified:

_____

_____

Individual's response to the plan: _____

_____

I agree to this plan and authorize _____ to send this aftercare plan/release summary (including physical/somatic, substance use data, and Advanced Medical Directives, if applicable) that has been prepared for me to the agencies/persons specified in Part IV and Part VII of the plan, and to the Core Service Agency responsible for managing and coordinating services identified in this plan for the purposes of continuity of treatment and services, and to facilitate access to resources. I further authorize the Hospital to disclose to the agencies/persons specified in Part IV of the plan those portions of my medical record, including physical (somatic) and substance use data, appropriate to the specific service provision. I have placed my initials in Part IV further acknowledging my consent to release this information. *Note: The individual cannot be denied treatment or services for failure to sign this "Consent for Release of Information".* This authorization is valid until _____ (not longer than one (1) year). The information may be subject to redisclosure as permitted by law.

I understand that I may revoke this authorization at any time. Any disclosure made before the date of revocation is not affected by the revocation.

_____	_____	_____
Signature of Person Leaving Facility or Guardian	*Relationship*	*Date*
_____	_____	_____
Signature of Witness	*Position*	*Date*
_____	_____	_____
Signature of Person Completing Aftercare Form	*Position*	*Date*

Addressograph

The authorization for release of medical records was not signed because _____

_____

Physician Assessment of Risk to Self or Others

(Facility may use this format or attach a separate Risk Assessment Addendum completed by the physician)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This evaluation and assessment was completed on ____/____/____ (date) at _____ (time). It reflects the patient's condition at that time.

_____ _____ _____

Signature of Physician **Date** **Time**

Name of Physician: _____

Addressograph