Substance Use Discharge Note
(Detoxification, Rehab, Halfway House)

Please fax 24 hours prior to discharge to **1-844-214-2469** .

IMPORTANT NOTE ABOUT DETOXIFICATION ADMISSIONS: Please fax to **1-855-301-5356** 24 hours prior to discharge with admission and discharge information as detox admissions are NOTIFICATION ONLY. AmeriHealth Caritas Iowa Behavioral Health Utilization Management (BH UM) will call or fax you an authorization number once form is accepted.

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 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?	☐ Yes ☐ No

Please complete American Society of Addiction Medicine (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:

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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:
Is member stepping down to a lower level of substance use care? ☐ Yes ☐ No If so, what level of care? If provider is requesting a step down level of care, we recommend calling BH UM to provide discharge information and complete a clinical review for an authorization in the step down level of care.

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:

Aftercare appointment 2	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Comments:	

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: