Mental Health Discharge Summary/ Billing Form

NAME/MRN

Facility Name: __________________ ID: _______ Program Name: _____________________ ID: _________

Provider: ______________________ ID: _______ Elapsed Time (Total Minutes): ______________

Service (Begin) Date: ____________________ Begin Time: 12:00 am

Code Activity: ☐ **315** Plan Dev ☐ **571** CM-Plan Dev ☐ **364** MD Plan Dev ☐ **540** Non-Bill

Location: ☐ Office ☐ Phone ☐ Telehealth – Pt Home
☐ Field ☐ Home ☐ Telehealth – Other than Pt Home
☐ School

1. **DISCHARGE DIAGNOSIS**: ICD-10 Code, DSM-5 Diagnosis and Narrative

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Primary)

DSM-5 Narrative Diagnosis: ____

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

2. **COURSE OF TREATMENT**:
   a. Opening and Closing Dates: ____
   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):

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3. **DISCHARGE PLANS:**

a. Recommendations:

b. Possible Future Problems:

c. Referrals Out:

Signature/License/Designation	Printed Name	Date
Co-Signature/license (if applicable)	Printed Name	Date

Use Next Page for Additional Information

Data Entry Clerk Initials ____________

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Space for Data Continuation ***(Specify which item you are continuing from)***