CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Mental Health Discharge Summary/ Billing Form

NAME/MRN

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

Service Category:

☐ CPT/HCPC Service Provided ☐ Lockout - CPT/HCPC Service Provided

☐ Other Nonbillable Service Provided:
☐ Money Management ☐ Providing transportation ☐ Leaving voicemails
☐ Coordination of logistics ☐ Clerical work ☐ Other _____

Direct Service Time (Min): _____ Documentation Time (Min): _____ Travel Time (Min): _____

Number in Group: _____ CPT/HCPC Code: _____

Location of Service (Please check one)

☐ Age-Specific Community Center
☐ Client's Job Site
☐ Correctional Facility
☐ Faith-Based
☐ Field
☐ Health Care/Primary Care
☐ Home
☐ Homeless/Emergency Shelter
☐ Inpatient
☐ Mobile Service
☐ Non-Traditional service location
☐ Office
☐ Other Community Location
☐ Phone–provided in client's home
☐ Phone–provided other than in client's home
☐ Residential Care - Adults
☐ Residential Care - Children
☐ School
☐ Telehealth/Video-provided in client's home
☐ Telehealth/Video-provided other than in Client's home
☐ Unknown/Not Reported

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

Did this service involve interactive complexity? ☐ Yes ☐ No

Did this service include the interpretation of results and explanation to the client/family? ☐ Yes ☐ No

For Clients Under 21 only:

Is this an ICC Service? ☐ **Yes** ☐ **No** Is this service linked to a Child and Family Team? ☐ **Yes** ☐ **No**

COUNTY STAFF ONLY: Does this service fall under FFPSA (Qualified Individual? ☐ **Yes** ☐ **No**

Was an Interpreter used? ☐ Yes ☐ No Name of Interpreter: _____

Language

Language service provided in other than English: ☐ Spanish ☐ Other _____

Is the client pregnant? ☐ Yes ☐ No (If yes, please document how service was pregnancy-related)

EBP/Service Strategies:

☐ Assertive Community Treatment
☐ Supportive Employment
☐ Supportive Housing
☐ Family Psychoeducation
☐ Integrated Dual Diagnosis Treatment
☐ Illness Management and Recovery
☐ Medication Management
☐ New Generation Medications
☐ Therapeutic Foster Care
☐ Multisystemic Therapy
☐ Functional Family Therapy
☐ Peer/Family Delivered Services
☐ Psychoeducation
☐ Family Support
☐ Supportive Education
☐ In Partnership w/ Law Enforcement
☐ In Partnership w/ Health Care
☐ In Partnership w/ Social Services
☐ In Partnership w/ SA Services
☐ Integrated Services for MH/Aging
☐ Integrated Services for MH/DD
☐ Ethnic-Specific Service Strategy
☐ Age-Specific Service Strategy
☐ Unknown Service Strategy

NAME / MRN

Evidence-based practice/tracking program? ☐ **Yes** ☐ **No** **Program** _____

This service was provided via telehealth with the consent of the client or authorized representative. ☐

1. **DIAGNOSIS:**

   Primary
   ICD-10 Code: _____ DSM-5 Narrative: _____

   Secondary
   ICD-10 Code: _____ DSM-5 Narrative: _____

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:

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

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

Data Entry Clerk Initials _____