

Admission or Discharge

NAME/MRN _____

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

ADMISSION

Admission Date: _____

Admission Diagnosis:

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

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

Substance use or dependence issue? **Yes** (add diagnosis below) **No** **Unknown**

Substance Use Diagnosis ICD-10 Code: _____ DSM-5 Narrative: _____

Living arrangement: _____

Conservatorship/Court status: _____

Has the client experienced traumatic events? **Yes** **No** **Unknown**

Is the client a caregiver? **Yes** **No** **Unknown**

Number of Dependents OVER 18 years of age: _____

Number of Dependents UNDER 18 years of age: _____

Referral Source: _____

Admitting Provider: _____

Primary Service Provider: _____

Psychiatrist: _____

DISCHARGE

Discharge Date: _____

Referred to:

(1) _____

(2) _____

NAME/MRN _____

Discharge Reason: _____

If Medical Necessity not met: Referred to:

Managed Care Plan Fee-for-service provider No Referral

Other: _____

Signature/License/Designation

Printed Name

Date

Co-Signature/license (if applicable)

Printed Name

Date

Data Entry Clerk Initials _____