SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Discharge Form
MH Contracted Agencies

MR#:
Name:

NOTE: If you need to make a change to any of the information on this form that has already been submitted to MIS, simply cross out the information, write the correction above or next to it and re-submit to MIS at fax number 650-573-2110.

Discharge Information

Client Information					
Last Name		First Name		MI	
Birth Date		Medical Record #			

Discharging Agency Information	
Agency/Provider/Team	
Discharge Date	
Discharge Therapist Name	

Medications at Discharge

Current Medications *(incl. Prescriber, Medication Name, Usage, Dosage, Frequency, Adherence, Adverse Reactions, Response, Start Dates)*

Current RX Med.	Amount	Frequency	Prescribed By	Purpose of Med.
OTC/Herbs	**Amount**	**Frequency**	**Prescribed By**	**Purpose of Med.**

CONFIDENTIAL PATIENT INFORMATION:
See California Welfare and Institutions Code Section 5328

Living Arrangement at Discharge

Living Arrangement (CSI)

- ☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.)
- ☐ House or apartment and requiring some support with daily living activities (applies to adults only)
- ☐ House or apartment and requiring daily support and supervision (applies to adults only)
- ☐ Supported housing (applies to adults only)
- ☐ Board and Care
- ☐ Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
- ☐ Justice Related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- ☐ Community Treatment Facility
- ☐ Mental Health Rehabilitation Center (24 hour)
- ☐ Skilled Nursing Facility / Intermediate Care Facility / Institute of Mental Disease (IMD)
- ☐ Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
- ☐ State Hospital
- ☐ Residential Treatment Center (includes Levels 13-14 for children)
- ☐ Group Home (includes Levels 1-12 for children)
- ☐ Foster family home
- ☐ Homeless, no identifiable residence
- ☐ Other
- ☐ Unknown / Not Reported

Homeless Category (CSI)

Required if indicated Homeless above

- ☐ Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street (Including vehicle, RV, tent)
- ☐ Permanent Supportive Housing
- ☐ Unknown

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Client Diagnosis at Discharge

Problem List							
DSM V Diagnosis / Problem List Item	ICD 10 Code	Date Added	Date Removed	Added or Removed By (Full Name of Staff)	Provider Title / Discipline	Primary Dx	SUD Dx
			This column will be implemented in early 2025.			☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

General Medical Conditions Check identifying physical health condition(s) as reported by client.			
17 = Allergies ☐	11 = Cirrhosis ☐	04 = Hyperlipidemia ☐	31 = Physical Disability ☐
16 = Anemia ☐	07 = Cystic Fibrosis ☐	05 = Hypertension ☐	08 = Psoriasis ☐
01 = Arterial Sclerotic Disease ☐	25 = Deaf/Hearing Impaired ☐	14 = Hyperthyroid ☐	36 = Sexually Transmitted ☐
19 = Arthritis ☐	12 = Diabetes ☐	13 = Infertility ☐	32 = Stroke ☐
35 = Asthma ☐	09 = Digest Reflux, Irritable Bowel ☐	27 = Migraines ☐	33 = Tinnitus ☐
06 = Birth defects ☐	34 = Ear Infections ☐	28 = Multiple Sclerosis ☐	10 = Ulcers ☐
23 = Blind/Visually Impaired ☐	26 = Epilepsy/Seizures ☐	29 = Muscular Dystrophy ☐	00 = No Gen. Medical Condition ☐
22 = Cancer ☐	02 = Heart Disease ☐	15 = Obesity ☐	37 = Other ☐
20 = Carpal Tunnel Syndrome ☐	18 = Hepatitis ☐	21 = Osteoporosis ☐	99 = Unk/Not Report'd. GMC ☐
24 = Chronic Pain ☐	03 = Hypercholesterolemia ☐	30 = Parkinson's Disease ☐	31 = Physical Disability ☐

Discharge Form Finalization

Assessor's Name/Discipline – Printed Conducted the Mental Status Exam and provided Diagnosis.	**Assessor's Signature and Discipline**	Date
Authorized Clinical Staff* – Printed	**Authorized Clinical Staff*** Signature and Date	Date

Assessor **must** be a *Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.*

(At minimum the assessor is responsible for reviewing the completed assessment, conducting the mental status exam, providing a clinical formulation and providing the diagnosis. Assessor signs here to co-sign for assessments provided by trainees.)

*Authorized Clinical Staff is the supervisor who co-signs the notes for those assessors who require co-signature.