



# Psychiatric Inpatient Discharge Form

Phone Number: 1-800-818-5837 Fax Number: 1-866-617-4967

## Section 1 Member Information

Member Name: (Last, First, MI)	Member ID:
Member Address at Discharge: (No., Street, City, State, Zip)	Phone Number at Discharge: ( )
Do you require assistance with a referral for follow up with our Molina Member: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe referral needs:	

## Section 2 Facility Information

Name (Attending Provider):	Phone Number:	Fax Number:
Address:	( )	( )
NPI:	TPI:	

## Section 3 Discharge Information

Admit Date (required): / /	Discharge Date: / /
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## Section 4 DSM-IV at Discharge

Axis I (Include all):	Axis II:
Axis III:	Axis IV: Axis V GAF:

## Section 5 Discharge Medications

Medication at Discharge:

## Section 6 Follow Up Information

Follow up (check all that apply): <input type="checkbox"/> PCP <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Therapist <input type="checkbox"/> Other (Specify: _____)
Appointment Dates: / / Times: / /
Provider Information for Follow up Appointments (Name and Contact Information):

## Section 7 Signature and Title

A TMHP number (for STAR + PUS members only) will be issued to your organization after receipt of Psychiatric Inpatient Discharge Form.
Signature (Person completing form): Title:

Additional Information (For Molina Healthcare of Texas Use Only):
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