YouthCare HealthChoice Illinois

SUBMIT TO
Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

DISCHARGE CONSULTATION DOCUMENTATION

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

DISCHARGE CONSULTATION INFORMATION

Member Name ____________________

Member DOB ____________________

Member ID # ____________________

Member Address ____________________

Facility Name: ____________________

Facility Fax Number: ____________________

Member Phone: ____________________

Parent / Guardian Name: ____________________

Best Time to Reach Member/Parent/Guardian: ____________________

UM Name: ____________________

Emergency/Other Contact: ____________________

Outpatient Therapist ____________________

Outpatient Therapist Phone ____________________

Date of next appointment ____________________

Case Manager (*if applicable*) ____________________

Case Manager Phone ____________________

Psychiatrist ____________________

Psychiatrist Phone ____________________

Date of next appointment ____________________

Does the member have medication to last until this follow-up?Yes☐ No☐

Other follow-up appointments: ____________________

Name/Type of Provider: ____________________ Phone: ____________________

Date of next appointment: ____________________ Did member attend a 513 (Bridge appt. during the discharge process? Yes ☐ No☐

If yes, name of staff conducting the 513: ____________________

Phone: ____________________ Date of the 513: ____________________ Time of the 513: ____________________

*****All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to Cenpatico to allow for assistance with the appropriate level of follow-up.**

Medical Provider/PCP ____________________ Phone ____________________

Current ICD Diagnosis

Primary ____________________

Secondary ____________________

Tertiary ____________________

Additional ____________________

Additional ____________________

Medication at discharge ____________________

Discharge Disposition/Where will member be staying after discharge? ____________________

____
Signature of Facility Staff

____
Signature of Member/Guardian

Date of Admission/Discharge

Time of Discharge

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