



Admission & Discharge Form

Confidential Patient Information under HIPAA
& 42 CFR Part 2

Admission Date:

Discharge Date:

Facility Name:	ID:	Admission Type <input type="checkbox"/> Scheduled <input type="checkbox"/> Unscheduled <input type="checkbox"/> Unknown
Program Name (Level of Care):	ID:	
Consumer/Beneficiary Name:	MRN:	
Primary Service Provider Name:	ID:	
Physician/LPHA Name:	ID:	

ADMISSION INFORMATION (choose 1 response only for each question below, unless otherwise noted)

Legal Class at Admission

<input type="checkbox"/> U99999 Unknown/Not Reported	<input type="checkbox"/> W53500 Temp Conservatorship	<input type="checkbox"/> W60000 Voluntary
	<input type="checkbox"/> W53550 Perm Conservatorship	<input type="checkbox"/> W99998 Other Involuntary Civil

Diagnosis:
Begin Date:
Begin Time:
Primary ICD 10:
Secondary ICD 10:

Diagnosis Type: Admission
Diagnosis By:

Referral Codes (choose up to 3):

<input type="checkbox"/> Adult Felon Drug Court	<input type="checkbox"/> Friends	<input type="checkbox"/> No Referral	<input type="checkbox"/> Psychiatric Emergency / Non-CCC
<input type="checkbox"/> AOD Treatment	<input type="checkbox"/> Homeless Service	<input type="checkbox"/> Other	<input type="checkbox"/> Referral Data Missing / NA
<input type="checkbox"/> Bay Area Community Resources	<input type="checkbox"/> Jail	<input type="checkbox"/> Other AOD Services	<input type="checkbox"/> Residential Treatment – Probation
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> John Muir Medical Center	<input type="checkbox"/> Other Community Referral	<input type="checkbox"/> Room & Board
<input type="checkbox"/> Children’s Group Home	<input type="checkbox"/> John Swett School District	<input type="checkbox"/> Other Psychiatric Hospital	<input type="checkbox"/> School or College
<input type="checkbox"/> Community Based Organizations	<input type="checkbox"/> Juvenile Hall	<input type="checkbox"/> Out of County Hospital	<input type="checkbox"/> Self
<input type="checkbox"/> County Health Clinics	<input type="checkbox"/> Kaiser	<input type="checkbox"/> Pittsburg Unified School District	<input type="checkbox"/> Self-Help Support
<input type="checkbox"/> Court/Criminal Justice	<input type="checkbox"/> Katie A	<input type="checkbox"/> Police	<input type="checkbox"/> Shelter – Non County
<input type="checkbox"/> Dependency Drug Court	<input type="checkbox"/> Mental Health / AODS Access Line	<input type="checkbox"/> Post Release Community Supervision	<input type="checkbox"/> Sober Living
<input type="checkbox"/> Dept Social Services – Foster	<input type="checkbox"/> Miller Wellness Center	<input type="checkbox"/> Primary Health Care	<input type="checkbox"/> Social Services
<input type="checkbox"/> DUI/DWI Program	<input type="checkbox"/> Mobile Response Team	<input type="checkbox"/> Private Practice (Non-MD)	<input type="checkbox"/> Telecare Hope House Crisis Res
<input type="checkbox"/> Early Childhood MH – Outpatient	<input type="checkbox"/> Mt Diablo Unified School District	<input type="checkbox"/> Private Psychiatrist	<input type="checkbox"/> West Contra Costa School District
<input type="checkbox"/> Employer/EAP	<input type="checkbox"/> Mt Diablo USD – WRAP Services	<input type="checkbox"/> Probation Department	<input type="checkbox"/> West County Adult – El Portal
<input type="checkbox"/> Family		<input type="checkbox"/> Prop 36	
<input type="checkbox"/> Forensic AOT			

DISCHARGE INFORMATION (choose 1 response only for each question below)

<p>Reason for Discharge:</p> <input type="checkbox"/> Completed Tx – Goals Reached, Referred <input type="checkbox"/> Completed Tx – Goals Reached, Not Referred <input type="checkbox"/> Completed Tx – Goals Not Reached, Referred <input type="checkbox"/> Completed Tx – Goals Not Reached, Not Referred <input type="checkbox"/> Mutual Agreement – Treatment Goals Partially Met <input type="checkbox"/> Mutual Agreement – Treatment Goals Not Met <input type="checkbox"/> Client Withdrew – AWOL, AMA, Tx Goals Partially Met <input type="checkbox"/> Client Withdrew – AWOL, AMA, No Improvement <input type="checkbox"/> Client Deceased <input type="checkbox"/> Client Moved Out of Area	<p>Discharge Status:</p> <input type="checkbox"/> Still a patient or expected to return <input type="checkbox"/> Discharged to home, self-care, foster care or shelter care <input type="checkbox"/> Discharged/transfer to residential/board and care (not locked, supervised living, no Tx) <input type="checkbox"/> Discharged/transfer to community residential treatment (not locked, custodial) <input type="checkbox"/> Discharged/transfer to community treatment facility (locked, no nursing care) <input type="checkbox"/> Discharged/transfer to skilled nursing facility / intermediate care facility <input type="checkbox"/> Discharged/transfer to acute care hospital or psychiatric health facility (PHF) <input type="checkbox"/> Discharged/transfer to state hospital <input type="checkbox"/> Discharged/transfer to jail <input type="checkbox"/> Discharged/transfer to medical unit <input type="checkbox"/> Deceased <input type="checkbox"/> Unplanned discharge <input type="checkbox"/> Other
---	---

<input type="checkbox"/> Client Incarcerated <input type="checkbox"/> Client Discharged – Administrative <input type="checkbox"/> Other <input type="checkbox"/> No Longer Meets Medical Necessity – Referred <input type="checkbox"/> No Longer Meets Medical Necessity – Not Referred	<input type="checkbox"/> Unknown / not reported <input type="checkbox"/> Discharged/transfer to another short term hospital <input type="checkbox"/> Discharged/transfer to another type of institution <input type="checkbox"/> Left against medical advice
---	---

AOD Counselor Printed Name/Title	AOD Counselor Signature/Title	Date
Date of Entry:		
Time of Entry: _____	Data Entry Staff Initials: _____	Data Entry Staff ID: _____