



Hudson River Region BHO

Behavioral Health Review Discharge

Name: Age: Insured ID:
 County: PH Plan:
 High need:

Does the consumer have a history of D/A service: Y N

Has the consumer signed an ROI: Y N

Level of care: IMH ID IR
 Type of review: First Cont'd Stay Step Down Discharge

Facility name:

Episode: Admission Date: Admission Hour:

Readmission: Y N U Readmission to the same provider: Y N

Date of Review:

Reviewer's Name: Title: Phone:

Clinician of Record: Phone: Ext:

Actual Discharge Date: Type of Discharge:

Housing Status At Admission:

Housing Status at DC: Same residence prior to admission: Y N

Education: Occupation: Legal:

Legal Guardian: Y N

Did the consumer have a behavioral health care coordinator prior to inpatient event: Yes No Unknown

Was the behavioral health care coordinator contacted by the hospital during inpatient stay: Yes No

<input type="text"/>	Was the discharging staff knowledgeable about the community treatment options:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Was a referral made to ACT/ICM/BCM:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	If ACT/ICM/BCM were involved prior to admission, did the inpatient program appropriately notify them of discharge:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Did the hospital on the previous admission send copies of the d/c plan and summary of treatment to the OP provider prior to the first appointment:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Were the multi-systems needs of the youth adequately assessed in the discharge plan:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Did the discharge plan adequately assess the need for referrals or linkages for provisions of basic need:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Did the discharge plan adequately assess whether the child has a parent/s who is/are able to care for him/her, or if there is no parent, the inpatient provider contacted:	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	Did the discharge plan adequately assess post discharge educational needs:	<input type="radio"/> Yes <input type="radio"/> No

Presenting Problem:

Assessment of Dangerousness

				Last review for this stay			
Suicidal Ideation:	<input type="radio"/> Y	<input type="radio"/> N		Suicidal Ideation:	<input type="radio"/> Y	<input type="radio"/> N	
Hx of Suicidal Ideation:	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Hx of Suicidal Ideation:	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U
Suicidal Attempts:	<input type="radio"/> Y	<input type="radio"/> N		Suicidal Attempts:	<input type="radio"/> Y	<input type="radio"/> N	
Hx of Suicidal Attempts:	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Hx of Suicidal Attempts:	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U
Plan:	<input type="radio"/> Y	<input type="radio"/> N		Plan:	<input type="radio"/> Y	<input type="radio"/> N	
Means:	<input type="radio"/> Y	<input type="radio"/> N		Means:	<input type="radio"/> Y	<input type="radio"/> N	
Access to Weapons:	<input type="radio"/> Y	<input type="radio"/> N		Access to Weapons:	<input type="radio"/> Y	<input type="radio"/> N	

Homicidal Ideation: Y N
 Hx of Homicidal Ideation: Y N U
 Homicidal Attempts: Y N
 Hx of Homicidal Attempts: Y N U
 Plan: Y N
 Means: Y N
 Access to Weapons: Y N

Last review for this stay

Homicidal Ideation: Y N
 Hx of Homicidal Ideation: Y N U
 Homicidal Attempts: Y N
 Hx of Homicidal Attempts: Y N U
 Plan: Y N
 Means: Y N
 Access to Weapons: Y N

Assaultive Behavior: Y N
 Hx of Assaultive Behavior: Y N U
 Aggressive Behavior: Y N
 Hx of Aggressive Behavior: Y N U
 Self Injurious Behavior: Y N
 Hx of Self Injurious Behavior: Y N U
 Able to Contract for Safety Y N

Last review for this stay

Assaultive Behavior: Y N
 Hx of Assaultive Behavior: Y N U
 Aggressive Behavior: Y N
 Hx of Aggressive Behavior: Y N U
 Self Injurious Behavior: Y N
 Hx of Self Injurious Behavior: Y N U
 Able to Contract for Safety Y N

Auditory: Y N
 Visual: Y N
 Command: Y N
 Hx of Command: Y N U
 Delusions: Y N
 Paranoia: Y N

Last review for this stay

Auditory: Y N
 Visual: Y N
 Command: Y N
 Hx of Command: Y N U
 Delusions: Y N
 Paranoia: Y N

Mood Labile: Depressed:
 Erratic: Manic:
 Appropriate:

Last review for this stay

Labile: Depressed:
 Erratic: Manic:
 Appropriate:

Affect Blunted: Restricted:
 Elated: Congruent:
 Appropriate:

Blunted: Restricted:
 Elated: Congruent:
 Appropriate:

Interventions

Ability to Care for Self: Y N U

Last review for this stay Y N U

Appetite:

Sleep:

Insight:

Judgment:

Impulse Control:

Memory:

Socialization:

Co-Occurring disorder: Yes No

Provider's plan for follow-up treatment:

Substance Use

Substance	Amount	Frequency	Last used	Method
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Current substance use: Yes No

Substance use history: Yes No

Tools used

CIWA	<input type="radio"/> Yes <input type="radio"/> No	Score	<input type="text"/>	COWS	<input type="radio"/> Yes <input type="radio"/> No	Score	<input type="text"/>
Audit	<input type="radio"/> Yes <input type="radio"/> No	Score	<input type="text"/>	DAST	<input type="radio"/> Yes <input type="radio"/> No	Score	<input type="text"/>

Diagnosis

Axis: Diagnosis:

Axis: Diagnosis:

Medications

Adherence to Meds: Yes No

Family/Support educated on consumer's meds: Yes No

Scripts provided to consumer upon d/c: Yes No

Has the consumer been educated on their medications: Yes No

How has the consumer been educated about their medications and contraindications:

Does the consumer understand how to take their medications: Yes No

Does the consumer have adequate access to the prescribed psychotropic medications: Yes No

Does the consumer intend to obtain timely refill prescriptions: Yes No

PH/BH Integration

Does the consumer have a physical health condition that interferes with activities of daily living: Yes No

Does the consumer's physical health condition influence their behavioral health disorder: Yes No

Is there a Health Home: Yes No Was Health Home notified: Yes No

Is there a care coordinator for the Health Home: Yes No Name:

Is there a PCP: Yes No PCP Involved: Yes No

Height(inches): Weight(lbs): BMI:  Automatically Calculated

Smoker: Yes No Cessation Discussed: Yes No

Transition Planning

Referral Type	Level of Care	Provider	Appt Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	:00/00/0000
<input type="text"/>	<input type="text"/>	<input type="text"/>	:00/00/0000

Was a PH referral indicated: Yes No

Was a MH referral indicated: Yes No

Was a D/A referral indicated: Yes No

Was a Housing referral indicated: Yes No

AOT petition filed: AOT petition outcome:

SPOA application submitted: Yes No Service requested:

Elements of D/C Plan:

Crisis/Wrap Plan: Yes No

Was consumer involved in D/C planning process: Yes No

Was the consumer involved in provider selection: Yes No

Was family/support system involved in d/c planning process: Yes No

Was the supports involved in provider selection: Yes No

Did the provider seek information about consumer preferences: Yes No

Did the provider assess the consumer's treatment expectations: Yes No

Is there evidence of a consumer's education about the MH or D/A system: Yes No

Was the discharging staff knowledgeable about the community treatment options: Yes No

Was a referral made to ACT/ICM/BCM: Yes No

If ACT/ICM/BCM were involved prior to admission, did the inpatient program appropriately notify them of discharge: Yes No

Did the hospital on the previous admission send copies of the d/c plan and summary of treatment to the OP provider prior to the first appointment: Yes No Date Sent:

Were the multi-systems needs of the youth adequately assessed in the discharge plan: Yes No

Did the discharge plan adequately assess the need for referrals or linkages for provisions of basic need: Yes No

Did the discharge plan adequately assess whether the child has a parent/s who is/are able to care for him/her, or if there is no parent, the inpatient provider contacted: Yes No

Did the discharge plan adequately assess post discharge educational needs: Yes No

Issues that interfere with consumer's recovery. Identify action steps planned to address barriers.

Barrier	Intervention
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>