



Hudson River Region BHO

Outreach

Name:

Age: Insured ID:

County:

PH Plan:

High Need :

Level of Care discharged from: IMH ID IR

Discharging facility:

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

Living situation:

Education:

Legal:

Occupation:

Supports

Name: Phone:

Type:

Follow-Up Appointments

Referral Type Level of Care Provider System Issue

Date/Time Reason Type Reason

Did the receiving provider receive the d/c plan and treatment summary: Yes No

Was it received prior to the first appointment: Yes No Date Received:

Did the receiving provider review the d/c plan and treatment summary: Yes No

Provider's Plan for Re-Engagement:

Outcome of call:

Referral Type Level of Care Provider System Issue

Date/Time : Reason Type Reason

Did the receiving provider receive the d/c plan and treatment summary: Yes No

Was it received prior to the first appointment: Yes No Date Received:

Did the receiving provider review the d/c plan and treatment summary: Yes No

Provider's Plan for Re-Engagement:

Outcome of Call:

Interventions

Please Identify the Care Monitor's suggested interventions

Additional Comments: