CVH-2 Rev.3/02 **CONNECTICUT VALLEY HOSPITAL - DISCHARGE/AFTERCARE PLAN**

[ ] General Psychiatry Division **Type of Discharge**: [ ] Facility Concurs (01) [ ] AWOL (05) [ ] Against Clinical Advice (12)
[ ] Addiction Services Division [ ] DMHAS Inpatient Transfer (04) [ ] Died (06) [ ] Against Medical Advice (02)
[ ] Whiting Forensic Division **PART I** [ ] 54-56d Court Discharge (07) [ ] Non-Compliant with Rules (13)

Patient Name _____ MPI # _____ Discharge Date _____ Discharge Time _____am/pm

Living Arrangement at Discharge:

___ Private Residence (12)
___ DMHAS Group Residence (01)
___ DMHAS Supported Apartment (02)
___ Home for Aged (06)
___ SNF/ICF/Nursing Home (05)
___ DMR Residence/Facility (07)
___ SRO-Hotel, YMCA, Rooming House (09)
___ Supervised Other (23)
___ Correctional Facility (10)
___ Street (11)
___ Shelter (13)
___ Hospice (14)
___ Other (98)

Facility Name:

Address:

Town:_____State:_____ Zip:

PPD Test Given? [ ] No [ ] Yes: Date: _____ Result:

Patient needs for continued care Recommended follow-up	Clinician or Agency	Telephone Number	Date/Time of Appointment
Medical:			
Psychiatric:			
Dental:			
Counseling/Therapy:			
Medication Follow-up:			
12 Step Group:			
Nutrition Follow-up:			
Other:			
Financial Resourses:			

Referrals (*Check all that apply*):

___ MH Residential (41)
___ SA Residential (42)
___ DMR Residential/IP (43)
___ DMR Non-Residential (44)
___ Nursing Home (SNF/ICF) (47)
___ Home for the Aged (48)
___ VA Residential IP (49)
___ VA Non-Residential IP (50)
___ IP Psych DMHAS (51)
___ IP Psych Gen. Hospital (52)
___ IP Psych Other (53)
___ IP SA DMHAS (54)
___ IP SA Other (55)
___ Crisis Bed/Respite (56)
___ Part. Hosp. Psych DMHAS OP/Fund (57)
___ Part. Hosp. Psych Gen Hospital (58)
___ Part. Hosp. Psych Other (59)
___ Part. Hosp. SA (60)
___ OP Psych/Csmgt DMHAS OP/Fund (61)
___ OP Psych/Csmgt Other (62)
___ OP SA/Csmgt DMHAS OP/Fund (63)
___ OP SA/Csmgt Other (64)
___ Crisis SV Follow (65)
___ General Hospital/Medical (66)
___ Criminal Justice System (68)
___ Hospice (69)
___ No Referral/Client Refused (90)
___ No Referral/Services Not Needed (91)
___ No Referral/Other (92)
___ Other (98)_____ ___ Unknown (99)

Community Contact/Case Manager:

Telephone Number:

Signature: Social Worker or Case Coordinator

PART II Medications and/or Other Instructions

Instructions Given to: Patient [ ] (and/or) Other [ ] _____ I hereby authorize that the above stated address may be released by Connecticut Valley Hospital to State, City Welfare and Social Security Agencies when deemed appropriate for the purpose of expediting claims and payment related to my hospitalization. I have received a copy of this discharge plan and understand all instructions.

Patient/Client or Family Member Signature_____Date

Physician Signature_____ Nursing Signature

WHITE- Patient YELLOW- Medical Record PINK- Continuing Care Provider/Case Manager