

DISCHARGE FORM
PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES
for Wyoming EqualityCare

Client Name:

DOB:

Client EqualityCare #:

Hospital:

Hospital UR Representative:

Phone #:

Fax #:

Admission Date:

Discharge Date:

Discharge Location: (where/ with whom)

Phone number:

Address:

Discharge Plan: (providers with appointment dates/times)

Discharge Meds (with dosages/ frequency):

- | | |
|-----------|------------|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

Medication Management Follow-up: (provider with appointment date/ time)

Community Collaboration: To whom did facility send discharge information to ensure success in the community? What information was sent?

OP Providers:

Schools:

Other:

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyoming.apshealthcare.com