SUBSTANCE ABUSE PREVENTION AND CONTROL
DISCHARGE AND TRANSFER FORM-ALL LEVELS OF CARE EXCEPT RBH

1.Today's Date:	2. ☐ Grace Period: Length of Stay ≤ 7 days? Specify number of days: _____		
PATIENT INFORMATION			
3. Name (Last, First, Middle):	4. Date of Birth: (MM/DD/YY):	5. Medi-Cal or MHLA Number:	
6. Address:			
7. Phone Number:	Okay to Leave a Message? ☐ Yes ☐ No	8. Gender:	
9. Admission Date:	10. Discharge or Transfer Date:	11. Discharge or Transfer Diagnosis:	

DISCHARGING PROVIDER	**ACCEPTING PROVIDER (IF TRANSFERRED)**
12. Provider Agency Name:	16. Provider Agency Name:
13. Address:	17. Address:
14. Contact Person:	18. Contact Person:
15. Contact Person Phone Number:	19. Contact Person Phone Number:

REASON FOR DISCHARGE OR TRANSFER	
20. ☐ Completed treatment goals/plan at this level of care ☐ Completed treatment goals/plan at this level of care and transferred ☐ Left before completing treatment goals/ plan ☐ Left before completing treatment goals/plan and transferred ☐ Voluntary (Specify): ☐ Administrative discharge (Specify):	☐ Discharged into other, more appropriate system of care (e.g., mental health, acute care hospital) Specify: ☐ Incarceration ☐ Death ☐ Other (Specify):

21. If transferred to another level of SUD care, please check if:

☐ Transferred to a **higher** level of SUD care ☐ Transferred to a **lower** level of SUD care

22. A description of each trigger for relapse, and a relapse prevention plan for each trigger (please use additional sheets if necessary):

23. Justification for Transfer or Discharge:

24. A narrative summary of the treatment episode including prognosis:

25. Prescriber Name and Medications (Including dosage):

26. Has the Patient Been Screened for Whole Person Care (WPC)? ☐Yes ☐ No If no, is the Patient Interested?

27. Has a copy of the Discharge and Transfer Form been given to the patient or guardian? ☐ Yes ☐ No. If no, please explain:

28. Counselor or LPHA Printed Name:	29. LPHA License #
30. Counselor or LPHA Signature:	31. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

DISCHARGE AND TRANSFER FORM INSTRUCTIONS

1. Enter today's date.
2. Grace Period: Check box if residential stay was 7 calendar days or less.

PATIENT INFORMATION

3. Enter the patient last name, first name, middle initial.
4. Enter the patient date of birth.
5. Enter the patient Medi-Cal or MHLA number.
6. Enter the patient address.
7. Enter the patient phone number and check box if okay to leave a message.
8. Enter the patient gender.
9. Enter the patient admission date into treatment.
10. Enter the patient date of discharge or transfer.
11. Enter the patient discharge or transfer diagnosis.

DISCHARGING PROVIDER INFORMATION

12. Enter the provider agency name.
13. Enter the provider agency address.
14. Enter the name of the contact person at the discharging provider agency.

15. Enter the phone number of the contact person.

ACCEPTING PROVIDER INFORMATION (if transferred)

16. Enter the provider agency name.
17. Enter the provider agency address.
18. Enter the name of the contact person at the accepting provider agency.
19. Enter the phone number of the contact person.

DISCHARGE OR TRANSFER LEVEL OF CARE INFORMATION

20. Check the box with corresponding reason for discharge or transfer.
21. Check the box if patient was transferred to a higher or lower level of SUD care.
22. Enter a description for each trigger for relapse, and a relapse prevention plan for each trigger (please use additional sheets if necessary).
23. Enter a justification for transfer or discharge.
24. Enter a narrative summary of the treatment episode including prognosis.
25. Enter the prescriber's name, patient's medications. Include dosages.
26. Check yes or no if the patient has been screened for Whole Person Care (WPC)? If no, is the patient interested? WPC-LA is a Medi-Cal 2020 waiver-funded program that will provide comprehensive and coordinated services to the sickest, most vulnerable LA County Medi-Cal beneficiaries such as individuals who are homeless, justice-involved, or have serious mental illness or severe and/or persistent substance use disorder or medical issues.
27. Check yes or no if a copy of this form has been given to the patient or guardian. If "no" please explain.
28. Enter Counselor or LPHA Printed Name.
29. Enter LPHA License if LPHA signing.
30. Enter Counselor or LPHA signature.
31. Enter Date Counselor/LPHA signed the form.

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

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SUBMIT THIS FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders.htm