CONTRA COSTA HEALTH MENTAL HEALTH SERVICES	**Mental Health Discharge Summary/ Billing Form**	NAME/MRN

Facility Name: ____________________ ID: _______ Program Name: ________________________ ID: _________

Provider: __________________ ID: _______ Service Date: ______________

Direct Service Time (Min): ________ Documentation (Min): ________ Travel Time (Min): ________

Number in Group: ______ CPT/HCPC Code: _____________ Quantity: ________

Location of Service (Please check one)

☐ Age-Specific Community Center
☐ Client's Job Site
☐ Correctional Facility
☐ Faith-Based
☐ Field
☐ Health Care/Primary Care home
☐ Home
☐ Nontraditional Location
☐ Homeless/Emergency Shelter
☐ Inpatient
☐ Mobile Service
☐ Non-Traditional service location
☐ Office
☐ Other Community Location
☐ Phone–provided in client's home
☐ Other __________________________
☐ Phone–provided other than in client's home
☐ Residential Care - Adults
☐ Residential Care - Children
☐ School
☐ Telehealth/Video-provided in client's home
☐ Telehealth/Video-provided other than in Client's
☐ Unknown/Not Reported
☐ Unknown

Is this a billable service? ☐ **Yes** ☐ **No**

Did this service involve interactive complexity? ☐ **Yes** ☐ **No**

Was an Interpreter used? ☐ **Yes** ☐ **No**

Name of Interpreter: _________________________________

Language

Language service provided in other than English: ☐ Spanish ☐ Other ____

Is the client pregnant? ☐ **Yes** ☐ **No (If yes, please document how service was pregnancy-related)**

EBP/Service Strategies:

☐ Assertive Community Treatment
☐ Supportive Employment
☐ Supportive Housing
☐ Family Psychoeducation
☐ Integrated Dual Diagnosis Treatment
☐ Illness Management and Recovery
☐ Medication Management
☐ New Generation Medications
☐ Therapeutic Foster Care
☐ Multisystemic Therapy
☐ Functional Family Therapy
☐ Peer/Family Delivered Services
☐ Psychoeducation
☐ Family Support
☐ Supportive Education
☐ In Partnership w/ Law Enforcement
☐ In Partnership w/ Health Care
☐ In Partnership w/ Social Services
☐ In Partnership w/ SA Services
☐ Integrated Services for MH/Aging
☐ Integrated Services for MH/DD
☐ Ethnic-Specific Service Strategy
☐ Age-Specific Service Strategy
☐ Unknown Service Strategy

(COUNTY STAFF ONLY) Evidence-based practice/tracking program? ☐ **Yes** ☐ **No** **Program** ____

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No**

1. **DIAGNOSIS:**

Primary ICD-10 Code: _____________ DSM-5 Narrative: ____

Secondary ICD-10 Code: _____________ DSM-5 Narrative: ____

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NAME / MRN

2. **COURSE OF TREATMENT**:
   a. Opening and Closing Dates: ______________________________
   b. Referral Source (reason for admission):
   c. Discharge Medications (include dosage and schedule, response, compliance, side effects, adverse labs, and other medication issues):
   d. Allergies: ______________________________
   e. Outcome (treatment highlights, modalities of treatment, goals obtained):

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3. **DISCHARGE PLANS:**
   a. Recommendations:
   b. Possible Future Problems:
   c. Referrals Out:

NAME / MRN ____________________

Space for Data Continuation *(Specify which item you are continuing from)*:

______________________	______________________	__________
Signature/License/Designation	Printed Name	Date
Co-Signature/license (if applicable)	Printed Name	Date

Data Entry Clerk Initials ____________

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