CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Admission or Discharge

NAME/MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

ADMISSION

Admission Date: _____

Substance use or dependence issue? **Yes** ☐ **No** ☐ **Unknown** ☐

Substance Use
ICD-10 Code: _____ DSM-5 Narrative: _____

Living arrangement: _____ Conservatorship/ Court status: _____

Has the client experienced traumatic events? **Yes** ☐ **No** ☐ **Unknown** ☐ Is the client a caregiver: **Yes** ☐ **No** ☐ **Unknown** ☐

Number of Dependents OVER 18 years of age: _____ Number of Dependents UNDER 18 years of age: _____

Referral Source: _____ Admitting Provider: _____

Primary Care Provider: _____ Psychiatrist: _____

DISCHARGE

Discharge Date: _____

Referred to:

(1) _____

(2) _____

Discharge Reason: _____

If Medical Necessity not met: Referred to:
☐ Managed Care Plan ☐ Fee-for-service provider ☐ No Referral

☐ Other: _____

_____ _____ _____
Signature/License/Designation Printed Name Date

_____ _____ _____
Co-Signature/license (if applicable) Printed Name Date

Data Entry Clerk Initials _____