MH 517
Revised 05/16/03

HOSPITAL DISCHARGE

Admission Date: _____ **Discharge Date*:** _____

Presenting Information: _____

Services Received and Response: _____

Medication(s): (Include Dosage & Response) ☐ None _____

Disposition and Recommendations: (If referred, include name of agency(s) or practitioner(s)) _____

_____ Referral Out Code _____

Diagnosis: (circle one)

Axis I Prin / Sec _____ Code _____

Prin / Sec _____ Code _____

Axis II Prin / Sec _____ Code _____

Axis III _____ Code _____

Axis V Discharge GAF _____ Prognosis _____

Signature & Discipline	Date	Reviewer's Signature & Discipline	Date

*Discharge Date: last service date or last cancelled or missed appointment.

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County - Department of Mental Health