

### HOSPITAL DISCHARGE

<b>Admission Date:</b> _____		<b>Discharge Date*:</b> _____	
<b>Presenting Information:</b> _____ _____ _____			
<b>Services Received and Response:</b> _____ _____ _____ _____ _____			
<b>Medication(s):</b> (Include Dosage & Response) <input type="checkbox"/> None _____ _____ _____			
<b>Disposition and Recommendations:</b> (If referred, include name of agency(s) or practitioner(s)) _____ _____ _____			
		Referral Out Code _____	
<b>Diagnosis:</b> (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.

<small>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 and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.</small>	<b>Name:</b> _____	<b>MIS #:</b> _____
	<b>Agency:</b> _____	<b>Prov. #:</b> _____
	<b>Los Angeles County - Department of Mental Health</b>	