

NETWORK PROVIDER DISCHARGE SUMMARY

Admission Date: _____		Discharge Date*: _____	
Presenting Information:			
Services Received and Response:			
Medication(s): (Include Dosage & Response) <input type="checkbox"/> None			
Disposition and Recommendations: [if referred, include name of agency(s) or practitioner(s)]			
Referral Out Code: _____			
Discharge Diagnosis:			
Axis I	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec	Code _____
		<input type="checkbox"/> Sec	Code _____
			Code _____
			Code _____
			Nomenclature _____
			Nomenclature _____
			Nomenclature _____
			Nomenclature _____
Axis II	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec	Code _____
		<input type="checkbox"/> Sec	Code _____
			Nomenclature _____
			Nomenclature _____
Axis III			Code _____
			Code _____
			Code _____
Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis (Check all that apply)			
1. <input type="checkbox"/> Primary support group 2. <input type="checkbox"/> Social environment 3. <input type="checkbox"/> Educational 4. <input type="checkbox"/> Occupational 5. <input type="checkbox"/> Housing 6. <input type="checkbox"/> Economics			
7. <input type="checkbox"/> Access to health care 8. <input type="checkbox"/> Interaction with legal system 9. <input type="checkbox"/> Other psychosocial/environmental 10. <input type="checkbox"/> Inadequate information			
Axis V Discharge GAF: _____		Prognosis: _____	
*Discharge Date: last service date or last cancelled or missed appointment			
Signature & Discipline _____		Co-Signature & Discipline _____	
Date _____		Date _____	
<p>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 prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>		Name: _____	
		DMH Client ID#: _____	
		Individual/Group/Organizational Provider Name: Los Angeles County – Department of Mental Health	