Employer/Health Plan: ___________

INTEGRATED BEHAVIORAL HEALTH
DISCHARGE SUMMARY

1. Patient Name : ______________________ DOB: ______________________________

   Insured Name: ________________________ Insured SS#: ___________________________

2. Date Treatment Began: _________________ Date of Discharge: _____________________

3. Discharge Diagnosis *(All 5 Axes REQUIRED)*:

	Code	**Name**
Axis I (1):	________	______________________
(2):	________	______________________
Axis II:	______________________________	
Axis III:	______________________________	

Axis IV (Stressor): ______________________

Axis IV (Severity): 6 5 4 3 2 1 0

Axis V: ______________________________

Current GAF: ___________________________

Highest GAF Past Year: ___________________

GAF at **Admission**: _____________________

4. Please rate extent to which patient achieved treatment goals (check one):

   ❑ none ❑ some ❑ most ❑ all

   Comments:

5. Please state your estimate of potential relapse:

   ❑ low ❑ moderate ❑ high

   Factors:

6. Discharge recommendations/Aftercare plans:

   (Please include referrals made to community resources)

Provider: ____

Name (print) Signature Date

Return Address: **Integrated Behavioral Health**
Care Management Services
or **P. O. Box 30018**
Laguna Niguel, CA 92607-0018
Confidential Fax: **(714) 556-5430**

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