



777 Woodward Ave., Suite 700
Detroit, MI 48226

1-888-437-0606
TTY: 711
mimeridian.com

BEHAVIORAL HEALTH DISCHARGE TRANSITION OF CARE FORM
Behavioral Health Care Coordination

Complete this form and fax it to MeridianHealth (Meridian) and the member's PCP at the time of discharge.

Member Information

Member Name _____
Member ID _____
D.O.B. _____

Member's Discharge Demographics

Address _____
City _____ State _____ Zip _____
Phone Number(s) _____

Check if any of the following apply upon discharge:

- Homelessness – lacks a fixed, regular and adequate nighttime residence.
- Imminent Risk of Homelessness – will imminently lose primary nighttime residence within 14 days or lacks the resources or support networks needed to obtain other permanent housing.
- High-Risk of Homelessness – has not had a lease, ownership interest or occupancy agreement in permanent housing during the last 60 days or had two or more moves during the preceding 60 days.

Medical Intervention, if Applicable _____

Primary Care Provider (PCP) Coordination

PCP Name _____
PCP Phone # _____
PCP Fax # _____
Date last notified _____
Faxed this form to PCP? Yes No
If no, why? _____

PCP Appointment upon Discharge

Appt. Date _____ Appt. Time _____

BH Appointment (within 7 days of discharge)

Provider Name _____
Provider Phone # _____
Appt. Date _____ Appt. Time _____

Acute Service Provider Information

Admitting Service Provider _____

Admit Date _____ Discharge Date _____

DSM-5 Diagnosis

ICD-10 Code	Diagnosis

Reason for Admit _____

BH Status upon Discharge _____

Significant Medical History _____

BH Appointment (within 30 days of discharge)

Provider Name _____
Provider Phone # _____
Appt. Date _____ Appt. Time _____

Clinic or Support Group Appointment (optional)

Agency Name _____
Appt. Date _____ Appt. Time _____

Discharge Medication

	Name	Dose	Qty.	Date	Meds	Script
1.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
5.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
6.	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Use additional forms if necessary. Please fax to MeridianHealth's Behavioral Health department at 313-309-8588.