Windstone Behavioral Health

Outpatient Discharge Summary

All Practitioners

Practitioner's Name and Licensure: ______________________________

Address: ____

City: ________________ State: _________ Zip: ___________

Medical Group/IPA: __________________________ Phone #: ___________________ Fax #: ___________________

Patient's Name: ____________________________________ Date of Birth: ________________ Date of Service: _____________

Previous Authorization #: ____________________ Total Sessions Completed: _________ Date of Last Visit: _____________

DSM 5 Diagnoses:

Axis I: *Alpha-Numeric Code:* ____________________ *Description:* ____

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Axis I: *Alpha-Numeric Code:* ____________________ *Description:* ____

Medical Diagnosis: *Alpha-Numeric Code:* ______________________ *Description:* ______________________________________

Psychological Factors: Check all that apply

- Access to health Care
- Housing
- Primary support group
- Economic
- Education
- Occupational
- Social environment
- Legal system / crime
- Other psychosocial or environmental issues

No symptoms present at Discharge (if symptoms present at discharge, please specify): ____________________________

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No Psychotropic Medications at Discharge (If psychotropic medications at discharge please specify below):

Discharge Psychotropic Medications:

Name of Medication: ____ Dosage/Frequency: ____________________

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Name of Medication: ____ Dosage/Frequency: ____________________

Name of Medication: ____ Dosage/Frequency: ____________________

Name of Medication: ____ Dosage/Frequency: ____________________

Service Disposition:

- Completed course of treatment
- Transferred to a higher level of care
- Patient terminated treatment
- Other (specify): ____
- Transferred to another practitioner, specify whom: ____

Patient has previously signed release of information to PCP and this form may be forwarded to PCP? Yes No

Practitioner's Initials: __________

PCP Name: ____ PCP Fax #: _______________________________

This information has been fowarded to the member's PCP Yes No (if no, please specify why): ________________

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Practitioner's Signature: ____ Date: ____________________

Please fax this form to (714) 644-8244