COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
DISCHARGE/TRANSFER FORM

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803
Website: http://publichealth.lacounty.gov/sapc/
Fax:
To check submission status call:

1. Name (Last, First, and Middle):	2. Date of Birth: (MM/DD/YY)	3. Medi-Cal Number:
4. Admission Date:	5. Discharge Date:	6. Discharge Diagnosis:

7. Narrative summary of the course of treatment episode:

8. Patient's Prognosis: ☐ Good ☐ Fair ☐ Poor
Please explain:

9. Description of relapse triggers and plan to avoid relapse when confronted with each trigger:

10. Medications: (include dosage & response).

11. Reason for Discharge/Referral:

- ☐ 1. Completed treatment goals/plan at this level of care (LOC) [option not available for WM; If Q94A=Yes, Q94 cannot=1; logic pattern]
- ☐ 2. Left before completing treatment goals/plan with satisfactory progress
- ☐ 3. Left before completing treatment goals/plan with unsatisfactory progress
- ☐ 4. Discharged by agency for cause (e.g., non-compliance with agency rules)
- ☐ 5. Incarceration [administrative discharge]
- ☐ 6. Death [administrative discharge]
- ☐ 7. Other
  - ☐7a. Designated SUD level of care (LOC) is not available at this site
  - ☐7b. Discharged into other, more appropriate system of care (e.g., mental health)
  - ☐7c. Does not meet SUD medical necessity
  - ☐7d. Specify_____

12. Recommendations for Follow Up:

13. Is a copy of this Discharge/Transfer Form provided to the patient? ☐ Yes ☐ No Explain:

14. Print Provider's Name:	15. Provider's Signature:	16. Date:

Client Name: _____ **Medi-Cal ID:**_____

Treatment Agency_____

DISCHARGE /TRANSFER FORM INSTRUCTIONS

The discharge plan shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the patient.

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal number.
4. Enter the patient's admission date.
5. Enter the patient's discharge date.
6. Enter the patient's discharge diagnosis.
7. Enter a narrative summary of the treatment episode. Describe services received and the patient's response.
8. Mark the appropriate box for patient's prognosis: "Good", "Fair", or "Poor", and provide an explanation.
9. Enter a description of relapse triggers and plan to avoid relapse when confronted with each trigger.
10. Enter the patient's medications. Include dosage and response.
11. Enter the reason for the discharge/referral. If none of the listed reason is applicable, check "Other" and provide an explanation.
12. Enter any recommendations for follow up including specify referred level/type of care.
13. If a copy of this form is provided to the patient, check "Yes"; otherwise, check "No" and provide an explanation.
14. Print the provider's name.
15. Enter the provider's signature.
16. Enter the date the provider signs the form.

SUBMIT THE DISCHARGE/TRANSFER FORM TO:

Mail:	Substance Abuse Prevention and Control 1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803
Fax:	(626) 299-4390
Website:	http://publichealth.lacounty.gov/sapc/