DISCHARGE INFORMATION FAX
Telephone: (205) 871-7814
Fax: (205) 868-9625

Today's Date:	**Date of Admission:** **Date of Discharge:**
Patient Name:	**Patient DOB:**
Patient Phone Number (*required*):	**Facility:**
Discharge To: **Address:**	**Step Down To: (circle applicable)** **Partial Hospitalization Program** **Intensive Outpatient Program** **Outpatient** **Mental Health Center**
MD Follow Up **Name:** **Appt Date/Time:** **Turnaround Time from Discharge:**	**Counselor Follow Up** **Name:** **Appt Date/Time:** **Turnaround Time from Discharge:**
Support System **Name:** **Contact Info:**	**Support System** **Name:** **Contact Info:**
UR Contact:	**UR Phone #:** **UR Fax #:**

Medication Orders

Name	Dosage	Route	Frequency

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Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract.