Final Disposition Form

Region I Acute Care Project

(Completed by the CM CSB for both Transfer & Discharge)

Currently in Private Hospital: _____ CM CSB: _____

Client: _____ Bed Dates Authorized: _____

Soc. Security or Client ID #: _____ Total Bed Days Used: _____

☐Transferred to State Facility / Date_____ ☐Discharged to Community / Date:_____

(Axis I) _____ Code(s): _____
(include co-occurring)

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(include co-occurring)

(Axis II) _____ Code(s): _____
(include co-occurring)

(Axis II)_____ _____ Code(s): _____
(include co-occurring)

Reason for Withdrawal (e.g. Third party payer identified): _____

Total length of stay in Private hospital (admission to discharge dates): _____

Check Transfer Criteria Met:

_____ Confirmed diagnosis of mental illness, **and**

_____ Acute and/or chronic medical conditions are stabilized, **and**

_____ Alternatives to admission have been investigated and there is no less restrictive alternative to admission, **and**

_____ Does not have any condition inappropriate for admission to a State Facility, **and one or more of following:**

_____ Is in imminent danger of self-harm; **or**

_____ Is at imminent risk of harming others; **or**

_____ Evidences of persistent inability or refusal to care for personal basic needs in a manner that is appropriate to his or he age or physical capacities and significantly threatens personal health and safety; **or**

_____ Has a condition that requires intensive monitoring of newly prescribed drugs with a high rate of complications or adverse reactions; **or**

_____ Has a condition that requires intensive monitoring and intervention for toxic effects from therapeutic psychotropic medication and short term community stabilization is not deemed to be appropriate

Clinical Status at Discharge / Transfer: *(check all that apply)*

- □ *Pre-hospital symptoms are reduced / resolved; and/or returned to pre-hospital condition.*
- □ *Able to follow treatment plan in the discharge setting.*
- □ *Aggression/threatening behavior reduced or resolved.*
- □ *Able to adhere to pharmacologic plan in the new setting.*
- □ *New symptoms emerge needing another treatment setting.*
- □ *Symptoms persist requiring rehabilitation.*
- □ *Willing to seek outpatient treatment.*

Project Discharge / Transfer Approval CSB Representative: _____
(Signature)

Fax to: **Regional HPR I Manager,** Dennis Vaughn: Fax: 434/970-1492