



Windstone Behavioral Health

OUTPATIENT DISCHARGE SUMMARY

DATE: _____

Patient Name: _____ DOB: _____ Member or SS #: _____

Insurance Company: _____ Medical Group: _____ Group Number: _____

Provider: _____ Telephone: _____ Fax: _____

Previous Authorization Number: _____ Total Sessions Completed: _____ Date of Last Visit: _____

Diagnosis Treated: Axis I _____ Code: _____

A Axis II: _____ Code: _____

Axis III: _____

Axis IV Severity Stressors: _____

Current Global Assessment of Functioning (GAF) Score AT Intake _____ At Discharge _____ (Low 10 - High 100)

SYMPTOMS PRESENT AT DISCHARGE: None

IF YES, please identify:

CONTINUED FUNCTIONAL IMPAIRMENT: NONE

IF YES, please identify:

DISCHARGE PSYCHOTROPIC MEDICATIONS: NONE

IF YES, please identify:

NAME: _____ DOSAGE: _____

NAME: _____ DOSAGE: _____

Service Disposition: The member (must select one):

Completed the course of treatment Transferred to a higher level of care

Self terminated Transferred to another provider, who:

Other, be specific: _____

This information has been forwarded to the member's PCP Yes No If not, why: _____

Provider Initials _____

Provider Signature: _____ Date: _____

PLEASE FAX THIS FORM TO (714) 384-3875