McLaren Flint
FLINT, MICHIGAN

# BEHAVIORAL HEALTH DISCHARGE ORDERS

**DISCHARGE DIAGNOSIS:**

❑ Major Depression
❑ Bipolar Disorder
❑ Schizophrenia
❑ Discharge diagnosis is different from admitting diagnosis
❑ Other___________________________

**REASON FOR HOSPITALIZATION:**

❑ Danger to self/others
❑ Gravely disabled
❑ Unable to recognize need to Psychiatric treatment
❑ Other_________________________________

**DISCHARGE MEDICATIONS**

*PHYSICIAN MUST COMPLETE MEDICATION RECONCILIATION FORM FOR ALL MEDICATIONS*

Antipsychotic Medications:

Patient being discharged with no Antipsychotic Medications prescribed.

Patient being discharged on the following Antipsychotic Medications:

______________________________________________________________________

______________________________________________________________________

**If more than one Antipsychotic – must complete information below**

Documentation of reason for multiple Antipsychotic Medications on discharge

1. History of 3 more failed trials of monotherapy. The following medications have failed to control the patient's symptoms: (Must list 3 or more medications used in the past)

Please check medications: ❑ Abilify ❑ Clozaril ❑ Geodon ❑ Haldol ❑ Invega ❑ Prolixin ❑ Risperdal
❑ Saphris ❑ Seroquel ❑ Thorazine ❑ Trilafon ❑ Zyprexa ❑ Other_______________

2. Plan to taper to Monotherapy. Note planned changes (taper) for each medication.

______________________________________________________________________

______________________________________________________________________

3. Augmentation of Clozapine. The following medication is being used to augment for symptom control:

______________________________________________________________________

**CONTINUED TREATMENT RECOMMENDATIONS:**

❑ Partial Hospitalization Program ❑ Inpatient Therapy ❑ Adult Foster Care
❑ Inpatient Medical Management ❑ Home Health Care ❑ Extended Care Facility

Other: ______________________________________________________________

**ACTIVITY/BATHING:**

❑ Activity as tolerated ❑ Sponge bath only
❑ No Driving ❑ Weight bearing status
Crutches/walker/cane ❑ Up in chair ❑ Regular
❑ No lifting/pushing/pulling ❑ Avoid stairs
❑ Shower/tub ❑ Lifting restriction ______lbs

**DIET:**

*Not following your diet may lead to worsening of your condition

❑ Low Salt ❑ Low Fat ❑ Cardiac ❑ Diabetic
❑ Renal ❑ Soft
❑ Special Restrictions:_________________________________

_______________________________________________________

**FOLLOW UP CARE:**

See discharge instructions for appointments.

You may return to work after _____ days.

TO/VO Read back and verified

**SPECIAL INSTRUCTIONS:**

(treatments, incision/wound care, equipment)

_______________________________________________________

_______________________________________________________

Physician Name: ____________________________ Nurse Signature: ____________________ Date:__________Time: __________

Physician Signature: __________________________

Date:___________ Time: _____________

PT.

MR.#/RM.

DR.

**BEHAVIORAL HEALTH DISCHARGE**

17889 (2/28/14)

640B