Behavioral Health Follow-Up After Hospitalization Evaluation

Instructions

•Complete this form in its entirety and send via SECURE email to BRO_FUH@louisianahealthconnect.com.

Member Information

Full Name: PLEASE PRINT _____ Medicaid Number: _____

Medicaid ID: _____ Marital Status □ Married □ Single □ Divorced □ Other

Date of Birth: MM/DD/YYYY _____

Phone: _____ Parish: _____

Address: _____

Is Member Homeless? □ Yes □ No

Current location of member: □ Home □ Family □ Shelter □ Group Home □ Other
If other please specify: _____

Alternate Contact: _____

Alternate Contact Address: _____ City, St, Zip: _____

Alternate Contact Phone: _____

Date and Time of Face-to-Face Assessment: _____

Power of Attorney (POA): □ Yes □ No □ Medical □ Financial □ Both POA Phone: _____

Curator: □ Yes □ No Name: _____ Phone: _____

Clinical Information

Hospital Discharged From: _____

Discharge Date: _____

Date of Scheduled Aftercare Appointment: _____ Provider Name: _____

Was the aftercare appointment scheduled within 7 days of discharge? □ Yes □ No

Did the hospital give member written discharge instructions before leaving the hospital? □ Yes □ No

If yes, ask to view the copy and review with member.

Current Medical Conditions

PHYSICAL/MEDICAL HISTORY VI. CURRENT MEDICAL CONDITIONS (Check all that apply; supporting documentation must be attached)

□ None Reported				
□ Pregnant Due date: Prenatal care:	□ Congestive Heart Failure Date of onset:	□ Asthma Date of onset:	□ Seizure Date of onset:	□ STI/STD Date of onset:
□ High Blood Pressure Date of onset:	□ Stroke Date of onset:	□ Emphysema Date of onset:	□ Cirrhosis Date of onset:	□ Chronic Pain Date of onset:
□ Heart Disease (specify): Date of onset:	□ Diabetes □ Insulin Date of onset:	□ Epilepsy Date of onset:	□ Digestive Problems Date of onset:	□ Thyroid Disease Date of onset:
□ Cancer (specify type): Date of onset: Life expectancy of less than 6 months? □ Yes □ No	□ Dementia □ Early Stage □ Late Stage Date of onset: Include proof of dx, such as MRI, CAT Scan, Neurological Exam	□ Underweight □ Overweight Date of onset:	□ COPD □ Oxygen □ No oxygen Date of onset:	Chronic kidney disease □ Stage 1 □ Stage 2 □ Stage 3 □ Stage 4 Date of onset:

□ Other/Describe:

List source of medical conditions noted above:

Medications

Please list all medications that are taken related to mental health that were prescribed prior to and during or following discharge?

Name	Dose/Frequency/Route	Current	Comments:
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	

Allergies: □ Yes □ No
Food Allergies: □ Yes □ No

□ Other/Describe:

Primary Care Physician: Name Phone Fax:

Additional Medical History Including Date of Onset:

_____

_____

If Injectable when was the last injection? _____

What provider is able to administer medication? *If no appointment, work with the member to schedule an appointment.*

_____

On a scale of 1-10 with 1 being extremely uncomfortable and 10 being extremely comfortable, how comfortable do you feel taking your medications? _____

Based on how comfortable you feel taking your medications is there anything preventing you from taking your medications or that makes you not want to take your medications (e.g. unpleasant side effects, worries about safety)? □ Yes □ No

If YES Please Explain: _____

- *Action: Educate member on the importance of medication adherence, what problems to call their behavioral health provider about, assist with obtaining prescription refills as needed and address additional barriers to medication adherence.*

Are there any barriers to obtaining your medication as often as needed (e.g. transportation to get to the pharmacy, being able to afford medications)? □ Yes □ No

If YES, Identify Barriers:

- *Action: If no transportation, arrange transportation.*

_____

Coordination and Discharge Planning

Do you have reliable transportation to your appointment: □ Yes □ No

Do you know your Behavioral Health providers phone number and office hours? □ Yes □ No

- *Actions: look up and communicate behavioral health provider's phone number, office hours, and address and give to member.*

Are there any other barriers that would prevent you from attending your appointment at the designated time (e.g., childcare issues, work conflicts)? □ Yes □ No

If Yes, Specify:

Is there anything else I can help you with?

- *Actions: Offer case management services to address the indicated needs and barriers.*

Does member agree to case management? □ Yes □ No

Was CM or DM intervention or Case Management Needed? □ Yes □ No

Who answered assessment questions? (Member, Family Member, etc.)

- *Action: Provide member with instructions for seeking emergency and non-emergency after-hours care.*
- *Emergency Louisiana Healthcare Connections BH Crisis Line: 1-866-595-8133*

- Non-Emergency BH Line: 1-866-595-8133
- After Hours Nurse Advice Hotline: 1-866-595-8133 (TTD/TTY: 711)

Printed Name of Evaluator: **Signature:**

License Number: Credentials:

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Is the member already active in care management for BH or PH co-morbidities: □ Yes □ No

Enroll member in program? □ Yes □ No

Identify CM or DM intervention that is needed (*identify member request for assistance and barriers to be addressed).*