



**Driscoll Children's Health Plan  
BH Discharge Summary**

**Phone: 1-877-455-1053**

**Fax: 361-653-0432**

**Member Information**

To: Driscoll Children's Health Plan Facility: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
Days Approved: \_\_\_\_\_ Days Denied: \_\_\_\_\_  
Auth Number: \_\_\_\_\_

**Follow Up Appointments**

MD: \_\_\_\_\_  
Counseling: \_\_\_\_\_  
Other: \_\_\_\_\_  
Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diagnosis**

Axis I: \_\_\_\_\_  
Axis II: \_\_\_\_\_  
Axis III: \_\_\_\_\_  
Axis IV: \_\_\_\_\_  
Axis V: \_\_\_\_\_  
Mental Status upon Discharge: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_