Banner University Health Plans
Banner – University Family Care

Out of Home Discharge Summary

Send completed form by fax to the BUHP Behavioral Health Department at (520) 874-3411 or BUHPBHUMPAMailbox@bannerhealth.com

Member Name: _____DOB: _____

Date of Admission: _____Date of Discharge: _____

Diagnosis at Discharge: _____

Outpatient Agency: _____Outpatient CM: _____

OOH Provider Agency: _____

OOH Type: ____ BHIF ____BHRF ____ HCTC

Name of Specific Home/Facility: _____

List each observable, measure goal that was addressed

Goal 1: _____

Was this goal completed? Yes/No/Partially _____

Goal 2: _____

Was this goal completed? Yes/No/Partially _____

Goal 3: _____

Was this goal completed? Yes/No/Partially _____

If there were more than 3 goals, please use a separate page to report.

1. What is the discharge placement? Include name of facility (if not home) and address:
   _____
   _____
   _____
2. Discharge follow up appointments:
   a. PCP _____
   b. CFT/ART meeting _____
   c. Psychiatric _____
   d. Therapy _____
   e. Other (please specify): _____
3. Current medications (list all name, dosage and frequency):
   _____
   _____
   _____
   _____
   _____
   _____