OPTUM™

PLEASE COMPLETE & FAX THIS FORM TO Optum/UBH/USBHPC Care Advocate Inpatient Follow-Up: FAX: 888-891-1281	Bridge on Discharge Session (Cannot occur prior to discharge) Hospital/Facility: _____ Date of Session: _____

Please Write Legibly

Patient Name: First: _____ Last: _____

Patient Date of Birth: ____/_____/_____ UB Rev Code: 0513 Member Insurance ID#: _____

Optum will contact patient within a few days of discharge to support their discharge plan. Please confirm:

Patient telephone number at discharge: _____

Patient address at discharge: _____

Check if the patient agrees to allow Optum to contact via:

☐ Secure email - indicate email address _____

☐ Texting – indicate best texting number _____

I certify that I met in person with this patient on the date indicated for a Bridge on Discharge session and completed the following:

- A mental status exam
- A clinically relevant risk assessment, including a risk/benefit analysis determining readiness for step down to aftercare
- A review of the discharge instructions from the hospital
- A review of medications (if applicable) to ensure that the patient has sufficient quantity until next appointment with prescriber
- An assessment of the patient's support system
- A review of the patient's follow-up appointment(s) to ensure the patient knows the time/date/location and how to contact their provider(s). If the patient refused an appointment, I educated the patient about the importance of timely follow-up and strongly encouraged the patient to accept assistance in scheduling an appointment to occur within 7 days of discharge
- A discussion about the importance of keeping their follow-up appointment(s) and how ongoing treatment supports the patient's recovery process
- A review of what to do in case of emergency including how to contact his/her doctor and/or therapist

Signature of licensed mental health provider, including registered nurse, counselor, therapist, social worker, psychologist, or physician, completing this post-discharge session:

Print Name: _____ Date: _____

Signature: _____ Credentials: _____

Phone: _____

Retain a copy of this form in the patient's chart