Behavioral Health Acute/RTC Discharge Summary Form

arkansas total care

Member Name:	Medicaid ID:	Date of Birth:
Facility Name:	Admission Date:	Discharge Date:
Follow-Up Appointment Scheduled: ☐ Yes ☐ No	Appointment Date:	
Provider Name/Type:	Walk-In Location:	
Medications at Discharge:	Education Provided: ☐ Yes ☐ No	
	Safety Plan Completed: ☐ Yes ☐ No	
	Crisis Contacts Provided: ☐ Yes ☐ No	
Primary Diagnosis:		
Discharge Rationale:		

Facility Certification (Name/Title): _____

Signature: _____ Date: _____