

CIGNA
IOP Discharge Summary

PLEASE PRINT OR TYPE ONLY

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____

UM NUMBER OF CARD-HOLDER: _____

SOCIAL SECURITY # OF CARD-HOLDER: _____

UTILIZATION REVIEW PERSON/COUNSELOR/ CARE MANAGER NAME AND PHONE

FACILITY'S NAME/CIGNA BEHAVIORAL HEALTH PROVIDER#: _____

WAS THIS MH OR CD IOP? _____

FIVE AXIS DX AT DISCHARGE:

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

OF IOP SESSIONS ATTENDED: _____ D/C DATE IS: __/__/__

THE REASON FOR THE DISCHARGE IS:

___ SUCCESSFULLY COMPLETED TREATMENT

___ BENEFITS EXHAUSTED

___ DROPPED OUT OR NO SHOWED MORE THAN ONCE

___ TRANSITIONING TO ALTERNATIVE LEVEL OF CARE (_____)

MEDS AT D/C: _____

PROGNOSIS: __ EXCELLENT __ GOOD __ FAIR __ POOR

THE FOLLOW UP APPOINTMENTS ARE AS FOLLOWS:

__ MD APPT WITH DR. _____ ON _____ FOR MEDICATION MGT.

__ THERAPIST APPT WITH _____ ON _____ FOR THERAPY

ANY OTHER RECOMMENDATIONS FOR THIS FOLLOW-UP CARE:

PLEASE FAX THIS FORM TO CIGNA: (860) 687-7329

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