attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

BEH Physician Discharge Note

Date: _____ **Time:** _____

Height: _____ cm Weight: _____ kg

Allergies:	[ ] No known allergies
[ ] Medication allergy(s): _____	
[ ] Latex allergy [ ] Other: _____	

Diagnosis

Axis I: (Principle Discharge Diagnosis)

Axis II:

Axis III:

Axis IV:

Axis V:

Past year:

Prognosis

Note:

Medication Planning Information

	NOTE: For patients discharged on two or more routinely scheduled antipsychotic medications: (Check all that apply)	
[ ]	History of three or more failed trials of monotherapy.	List medications that failed trials:
[ ]	Recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications.	List recommended medications to decrease:
		List recommended medications to increase:
[ ]	Cross taper in progress	List current medications being decreased:
		List current medication being increased:
[ ]	Augmentation of Clozapine:	

attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

BEH Physician Discharge Note

Date: _____Time: _____

	Suicidal / Homicidal
	Does the patient or others currently report:
Yes	**No**
[ ]	[ ] The patient having suicidal ideation or making suicidal threats?
[ ]	[ ] The patient having homicidal / assaultive ideations or making homicidal threats?
	If the answer to either question above is yes, answer the questions below
Yes	**No**
[ ]	[ ] Is the ideation repetative or persistant?
[ ]	[ ] Does the ideation involve serious intent / lethal intent?
[ ]	[ ] Does the patient have a specific plan?
[ ]	[ ] Does the ideation have delusional or hallucianatory content?
	NOTE: If the answer to any of the above questions is YES, describe the patient's plan, ideations, etc. and if represent a risk to others at the time of discharge. Describe considerations regarding "duty to warn".
Note:	

Outcome from the Hospitalization
Note:

Risk / Benefit of Treatment Plan
Note:

Yes	**No**
[ ]	[ ] Patient verbalizes understanding of proposed treament plan

Discharge Summary
Note:
Discharge Summary: [ ] Dictated [ ] Electronically documented

_____ _____ _____ _____

Date **Time** **Physician's Signature** **MD Number**