BERKELEY COMMUNITY MENTAL HEALTH CENTER
Hospital Discharge Assessment Form

Name:	**CID #:**
Was BCMHC involved in admission? ☐ **Yes** ☐ **No**	
Hospital Admission Date:	**Hospital Discharge Date:**
Name of hospital consumer admitted to:	
Did hospital send Discharge summary? ☐ **Yes** ☐ **No**	
Diagnosis (current; was this changed in the hospital?)**:**	
Mental Status: (appearance, affect, mood, judgment, perceptual disorder, insight, etc)	
Medications (name, dosage, etc; neuroleptic consent needed? Was the consumer given facts about meds while in hospital? What is the consumer's understanding of why the meds were RX'd?)**:**	
Side Effects? (AIMS if needed)	
Hospital experience (How was your hospital experience? Was it helpful? Did anything upsetting or frightening/scary happen? What? Include time from transport through discharge)	
Rate the hospital experience 1-10 (1=worst experience of my life; 10=very helpful, positive experience):	
Plan: (next appointment, Dr. appt., additions to treatment plan)	
Clinician signature/date:	