

Inpatient Follow-up Form

Tufts Health Plan Clinical Services – Mental Health Department

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Facility:		Date:	
Patient Name:		Tufts Health Plan Member ID #:	
Date of Admission:		Date of Discharge:	
Primary Discharge Diagnosis (only one diagnosis):			
Secondary Discharge Diagnosis (if applicable):			
After Care Plan	Provider Name	Phone Number	Appointment Date
Psychopharm:	_____	_____	_____
Psychotherapy:	_____	_____	_____
PH, IOP, ART:	_____	_____	_____
PCP or Medical Case Manager must be notified for authorization before SNF transfer or VNA referral			
SNF: _____			
VNA (Psych Nurse or Social Worker): _____			
<ul style="list-style-type: none">• If an appointment time is not listed please explain• Primary Care Physician (PCP) Follow-up does <u>not</u> count as a follow-up Mental Health Provider			
Did you notify the PCP of this member's admission? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Notified: _____			
For members transferred to a SNF or with a VNA referral Date of Notification of PCP or Medical Case Manager: _____			
Facility Discharge Planner Name:		Facility Discharge Planner Phone #:	

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