Direct Commitments and Diversions

Service Provider ☐ Date: ☐

Patient Information

Last Name: ☐ Suffix ☐ Patient ID ☐

First Name: ☐ Episode ☐

Gender: ☐ Date of Birth: ☐

Race: ☐ Hispanic ☐

County of Residence: ☐ ☐ Homeless ☐ Veteran SSN ☐

Commitment Information

Date of Admission: ☐ Status: ☐

County of Commitment ☐

Mental Hygiene Commissioner: ☐

Reference Source: ☐

Medical Information

Reason for Admission: ☐

☐ Is the patient Homicidal? ☐ Is the patient Suicidal? ☐ suicide attempted?

☐ Did patient Overdose? Drug(s): ☐ ☐ Is patient in withdrawal?

Disability Group: ☐ Diagnosis (DSM IV): ☐

Attending Physician: ☐ Diagnosis (DSM IV): ☐

Discharge Information

Date of Discharge ☐ Disposition: ☐

Outpatient Facility: ☐ Care Coordinator: ☐

Date of First outpatient Appointment: ☐

Billing Information

Billing Period: Date From: ☐ Date To: ☐

Service Code: ☐ Rate Per Unit. ☐ Units of Service: ☐

Amount Billed: ☐

Print Form