Transition Visit Form

Instructions: Please complete, sign, and date this form. Please write legibly.

Hospital/Facility Name: ____

Date: ____________________

Member Name (First, Middle, Last): ______________________________________

Date of Birth: ___________________ **Insurance ID#:** _________________________ **Rev Code:** 0513

MH/SA Primary Diagnosis __________________________ **MH/SA Secondary Diagnosis** _________________________
(Please ensure the primary and/or secondary ***SA diagnosis code*** is included on this form and the subsequent claims billed.)

Address at Discharge: ____

Telephone Number at Discharge: _______________________**E-mail Address:** __________________________________

1. I reviewed the crisis/safety plan with the Member and/or parent/guardian. I reviewed and identified needs, barriers, and updates to the plan.
   Needs and barriers discussed: ____

   Solutions to barriers: ____

2. I asked the Member and/or parent guardian if he/she has a relapse prevention plan and/or a Wellness Recovery Action Plan (WRAP). I reviewed and identified needs, barriers, and updates to the plan.
   Needs and barriers discussed: ____

   Solutions to barriers: ____

3. Please review with the Member and/or parent/guardian what to do in case of emergency. Please ensure that the Member and/or parent/guardian know the statewide, toll-free ESP/MCI number: 1-877-382-1609.

4. I reviewed the hospital discharge plan with the Member and/or parent/guardian. I asked if he/she had questions, concerns, needs, or barriers.
   Needs and barriers discussed: ____

   Solutions to barriers: ____

5. I reviewed the Member's follow-up appointment(s). I ensured that the Member and/or parent/guardian knows his/her appointment date and time, how to contact his/her provider, and the importance of keeping follow-up appointments. I strongly encouraged follow-up for Members who refused an appointment.
   Barriers to keeping aftercare appointment: _______________________________________

   Solutions to barriers: ____

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6. I reviewed expectations of treatment (frequency, counseling approach, and what the Member and/or parent/guardian expect from treatment, in his/her own words).
   ____

7. At or prior to discharge, the outpatient provider, prescriber, MBHP/HNE Be Healthy care manager, and primary care clinician were contacted and/or sent the following documents, with Member and/or parent/guardian consent:
   - ☐ Discharge instructions
   - ☐ Crisis plan, if applicable
   - ☐ Other____

8. I assessed with the Member and/or parent/guardian their natural support system.
   Existing and/or new resources identified: ____

9. I asked about barriers (financial, transportation, etc.) to filling prescription medications.
   Barriers discussed: ____

   Solutions to barriers: ____

10. Please inquire if the Member and/or parent/guardian are aware of additional MBHP/HNE Be Healthy services such as the Community Support Program (CSP), Children's Behavioral Health Initiative (CBHI) services, and substance use disorder services, as well as recovery-oriented/community-based services (e.g., self-help, peer support, parent support group, NAMI, AA/NA, clubhouses, recovery learning communities) and provide resource information in the Member's geographic region.

A list of statewide ESP/MCI providers, along with community-based resources and provider information can be found on the MBHP website at www.masspartnership.com/hne.

Comments: ____

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I, ________________________________, certify that I met in person with ________________________
(print name and credentials of the clinical staff) *(print name of the MBHP/HNE Be Healthy Member)*

on __________ for his/her aftercare visit and completed the Transition Visit form.
(date)

Master's-level mental health professional or psychiatric nurse completing this form:

Signature: ____ Date: ____________________

MBHP/HNE Be Healthy Member:

Signature: ____ Date: ____________________