|  |  |  |
| --- | --- | --- |
| Client:  | Case #:  | Program:  |
| Date of Service:       | Unit:        | SubUnit:        |
| Server ID:       | Service Time:        | Travel Time:        | Documentation Time:       |
| Person Contacted:       | Place:       | Outside Facility:       | Contact Type:       | Appointment Type:       |
| Billing Type (Language Service  Provided In):       | Intensity Type (Interpreter Utilized):       |
| Diagnosis At Service: ICD-10 Code(s):        | Service:        |

**CRISIS STABILIZATION UNIT (CSU) – DISCHARGE NOTE**

**CS Admit Time:**       **CS Admit Date:** Date

**CS Discharge Time:**       **CS Discharge Date:** Date

**Total Billing Time (SC90):**       **Total Non-Billing Time (SC813):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Admission (why admitted to CSU, include risk status, 5150 status, behaviors during course of treatment; Indicate any time not included in Total Billing/Non Billing Time due to release to Medical, ER, etc ):**

**Discharge Plan (Continue 5150 hold; is hold being discontinued; referrals given)**

**For more detailed discharge information, refer to Discharge Summary completed on:** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\***Signature/Title/Credential Date Printed Name/Credential/Server ID#

\*I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#