MH 224CI
Revised 10/1/15

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Close Inpatient Episode

Inpatient	**CLIENT I.D.#**
Last Name:	
First Name:	Middle:
Discharge Date:	Discharge Time:
Other Factors: Physical? Yes☐No☐ DD? Yes☐No☐ Dual Diagnosis:	
Referral Out Code:	
Referral Out Provider:	
Patient Status Code:	

DIAGNOSIS **Enter one Primary (required) and one Secondary Diagnosis (if applicable)**

Primary	Secondary	ICD Code	Diagnosis (Nomenclature)

Provider Name: _____ Provider Number: _____