|  |  |  |  |
| --- | --- | --- | --- |
| PATID: |       | Person Served: | Last:       First:       Middle Initial:        |
| Cost Center:       |
| Date of Admission:       | Date of discharge:       | Date of last contact:       |
| Type of discharge: [ ]  Planned [ ]  Unplanned [ ]  Deceased |
| Presenting concerns upon admission:      |
| **Services Provided** |
| [ ]  Individual Therapy  | [ ]  Case Management/Linkage | [ ]  Medication Management |
| [ ]  Group Therapy  | [ ]  Rehabilitation (individual/group) | [ ]  Collateral |
| [ ]  IHBS | [ ]  ICC | [ ]  TBS |
| [ ]  Crisis | [ ]  Family Therapy |  |
| Description of services provided and individuals response to services:       |
| Progress towards recovery/well-being and goal achievement:       |
| Education information (If applicable: grade level functioning, special education needs, IEP/504):       |
| Current medications prescribed (If applicable: including RX name, dosage, prescriber name):       |
| Plan for continued medication support:       |
| Response to medication(s) and reported side effects:       |
| Reason for discharge (planned or unplanned) from current program:       |
| Discharge diagnosis:       |
| Nature of diagnosis (what may be causing the symptoms):       |
| Status at discharge/last contact and follow up information:       Follow-up:

|  |  |
| --- | --- |
| Referred to program/provider:  |       |
| Address:  |       |
| Telephone:  |       |
| Hours/Days of Service:  |       -       [ ]  Mon [ ]  Tues [ ] Wed [ ]  Thurs [ ]  Fri [ ]  Sat [ ]  Sun |
| Appointment Date/Time:  |       /       [ ] am [ ]  pm |

 |
| **Discharge plan** |
| Recommended services and support for continued/future treatment:       |
| Potential outcomes and goals for continued treatment:       |
| Current support system:       |
| **Individual's description of:** |
| Strengths:       |
| Needs:       |
| Abilities:       |
| Preferences:       |
| **Resources provided** (medical, mental health, substance use and crisis resources): |
| Program/Provider Name | Phone | Address | Days and hours of service |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Court system/legal guardian notified of discharge (if applicable)** [ ]  N/A  |
| Date notified of discharge:       |
| Person notified:       |
| Additional information relevant to discharge:       |
| **For Unplanned Discharge:**  |
| If person served did not engage in treatment, list attempts made to contact individual:  |
|  | Date of contact | Type of contact: (Mail, Home Visit, Phone, Other-Field Attempt) |  |
|  |       |       |  |
|  |       |       |  |
|  |       |       |  |
| **Person Served:** |
| Service provided in person served preferred language: [ ]  Yes [ ]  No |
| Person served preferred language:       |
| Person served signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was person served signature unavailable: [ ]  Yes [ ]  No |
| Reason for no signature:       |
| **Support Person:** |
| Service provided in support person served preferred language: [ ]  Yes [ ]  No |
| Support person preferred language:      |
| Support person signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was support person signature unavailable: [ ]  Yes [ ]  No |
|  |
| Copy of plan offered: [ ]  Yes [ ]  No |