|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |
|  | | | | |  | | |  | | |  |
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|  | | | | |  | | |  | | |  |
|  | | | | |  | | |  | | |  |
| **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) | | | | | | |  | |
|  |  | |  | | | | | | |  | |
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|  |  | |  | | | | | | |  | |
| **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 | | | | | | | | | | | |