**Admission Transition Discharge (ATD)/Client ATD Form**

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| **Basic Client Information** |
| **Client Name:** |       | **DOB:** |       | **PATID:** |       |
| **Admission Information:** |
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| **Admission Date:** |       |  |
| **Treatment Program:** | [ ]  Individual Managed Care Provider Other:       |
| **Admission Comments:** |
|       |
| **Discharge Information** |
| **Discharge Date:** |       | **Discharge Practitioner:** |       |
| **Mutual Treatment Decision by Client and Provider** |  |
| **Discharge Reason:** (Must Select One) |
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| **Discharge Comments:** |
|       |
| **Evidence Based Practice (EBP) Information:**  |
| **Evidence Based Start Date:** |       | **Practitioner:** |       |
| **Evidence Based Practice:** (Select One) |
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| **Evidence Based End Date:** |       |  |
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| Submitted by: |       | Date: |       |
| Email: |       |
| Phone: |       |