|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Discharge Summary Form** | | | | | | |
| Use as Transfer Summary Form | | | | | | |
| Organization: | | | | | | |
| Programs or Services: | | | | | | |
| Interview – Date:  Interview Start Time:  Interview Stop Time: | | | | | Interview Type:  Phone  Face-to-Face (specify location): | |
| **DEMOGRAPHICS** | | | | | | |
| Individual Name: | | | | Prefers to Be Called: | | |
| Primary or Preferred Language:  English  Spanish  Other: | | | | | | |
| Preferred Method of Communication:  Oral  Written  Sign Language | | | | | | |
| Date of Birth: | | | | Country of Birth: | | |
| Birth Gender:  Male  Female  Gender Orientation:  Male  Female | | | | Race/Ethnicity: | | |
| Address: | | | | City: | | |
| State: | | | | Zip: | | |
| Phone: | | | | E-mail: | | |
| Marital/Relationship Status:  Single (never married)  Married – Years:  Partnered – Years:  Dating – Years:  Divorced – Years Married:  Separated – Years Married:  Widowed – Years Married: | | | | | | |
| Family/Guardian:  N/A | | | | Family/Guardian Contact (phone/e-mail):  N/A | | |
| Emergency Contact:  N/A | | | | Emergency Contact (phone/e-mail):  N/A | | |
| **CLINICAL/CASE MANAGEMENT** | | | | | | |
| Clinical/Case Record: | | | | Plan for Care, Treatment, or Services – Date: | | |
| Authorized Staff: | | | | | | |
| Admission or Entry – Date: | | | | | | |
| Reason for Care, Treatment, or Services: | | | | | | |
| **Sources of Information** | | | | | | |
| ***Individuals*** | | | | | | |
| Individual  Family/Guardian  Significant Other(s)  Licensed Mental Health Counselor (LMHC)  Licensed Practitioner of the Healing Arts (LPHA)  Licensed Mental Health Professional (LMHP)  Psychiatrist  Physician  Social Worker  Case Manager  Other Providers: | | | | | | |
| ***Documentation*** | | | | | | |
| Clinical/Case Record – Date:  Risk of Harm Screening Form – Date:  Suicide Risk Assessment Form – Date:  N/A  Medication Reconciliation Form – Date:  Strength Assessment Questionnaire – Date:  Spiritual Assessment Questionnaire – Date:  Behavioral/Emotional Assessment Form – Date:  Physical Pain Assessment Questionnaire – Date:  Physical Health Screening Form – Date:  Physical Health Examination Form – Date:  N/A | | Diagnostic Summary Form – Date:  Statement of Needs Form – Date:  Coping Strategies Preferences Form – Date:  Plan of Care, Treatment, or Services – Dates:  Progress Note Form – Dates:  Plan Review Form – Dates:  Discharge Summary – Date:  N/A  Recovery Safety Plan – Date:  N/A | | | | |
| **REVIEW** | | | | | | |
| ***Diagnostic Impression***from Diagnostic Summary Form | | | | | | |
|  | | | | | | |
| ***Treatment Recommendations*** from Diagnostic Summary Form | | | | | | |
|  | | | | | | |
| ***Goals*** from Plan for Care, Treatment, or Services | | | | | | |
| Goal 1.1: | | | | Defined – Date:  Projected – Date:  Achieved – Date: | | |
| Goal 2.1: | | | | Defined – Date:  Projected – Date:  Achieved – Date: | | |
| Goal 3.1: | | | | Defined – Date:  Projected – Date:  Achieved – Date: | | |
| ***Discharge Criteria*** from Plan for Care, Treatment, or Services | | | | | | |
| **Criteria 1:** | | | | Defined – Date:  Projected – Date:  Achieved – Date: | | |
| **Criteria 2:** | | | | Defined – Date:  Projected – Date:  Achieved – Date: | | |
| **Recommendations for Continuity of Care, Treatment, or Services:** | | | Defined – Date:  Projected – Date:  Achieved – Date: | | | |
| **Discharge Status** | | | | | | |
| Significant Findings: | | | | | | |
| Reason for Discharge: | | | | | | |
| ***Diagnosis at Discharge*** | | | | | | |
| Code: | Mild  Moderate  Severe  Individual Denies  N/A | | | | | |
| Code: | Mild  Moderate  Severe  Individual Denies  N/A | | | | | |
| ***Condition at Discharge*** | | | | | | |
|  | | | | | | |
| **Transfer/Referral** | | | | | | |
| ***Mental Health Services*** | | | | | | |
| *Mental Health Outpatient* | | | | | | |
| *CSS*  Case management  CILA  Group home  Housing  MISA | | | | | *Other Programs*  CABS/CAS  CABS/SASS  PRP  Vocational | |
| Provider/Facility: | | | | | | |
| Address: | | | | City: | | |
| State: | | | | Zip: | | |
| Phone: | | | | E-mail: | | |
| Reason for Referral: | | | | | | |
| ***Chemical Dependency Services*** | | | | | | |
| *Chemical Dependency Outpatient: Level I or II*  Level I  Level II  Other: | | | | | *Chemical Dependency Inpatient: Level III*  Detox (ATP)  Rehab (ATP)  WRS | |
| Provider/Facility: | | | | | | |
| Address: | | | | City: | | |
| State: | | | | Zip: | | |
| Phone: | | | | E-mail: | | |
| Reason for Referral: | | | | | | |
| ***Other Referrals and Continuing Care, Treatment, or Services*** | | | | | | |
|  | | | | | | |
| Plan for Care, Treatment, or Services updated, per above changes | | | | | | |
| **Required Attachments** | | | | | | |
| Assessments  Recovery Safety Plan  Medication Reconciliation Form  Release of Information Form (for all transfers and referrals)  Other: | | | | | | |
| **ATTESTATION** | | | | | | |
| Individual Signature: | | | | | | Date: |
| Family/Guardian Signature:  N/A | | | | | | Date: |
| Staff/Counselor Signature(s): | | | | | | Date: |
| QMHP/Supervisor Signature: | | | | | | Date: |
| LPHA/Physician Signature: | | | | | | Date: |