|  |
| --- |
| **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:  |