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| Person’s Name (First MI Last): | Record #: | Date of Admission: |
| Organization/Program Name: | DOB: | **Gender:**  Male  Female  Transgender |

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| **Transition - From (Unit/Program):** | | **To:** |
| **Discharge** | | |
| **Last Contact:** | **Discharge/Transition Date:** | |

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| --- |
| **Person’s location and contact information post discharge/transition: Address:**  **Unknown**  **Telephone:**  **Unknown**  **If discharged to shelter document efforts to prevent** |

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| --- |
| **Status at Last Contact:** |

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| **Summary of Services/Treatment Provided** (consider vocational, educational, financial legal, medical, behavioral, and risk status): |

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| --- |
| **Outcomes** (Include qualitative and quantitative information regarding progress/gains achieved, strengths, abilities and preferences. Specify any standardized measures used)**:** |

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| **Health and Safety Concerns (include behavioral, medical and/or substance use issues):**  Not applicable |

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| **Status Towards Meeting Goals** (NM=Not Met, PM=Partially Met, M=Met, D/C=Discontinued) | | | | | | |
| **Goal #** | **Keyword** | NM | **PM** | M | **D/C** | **Comments** |
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| **Overall Progress In Treatment:** | | | | | | |

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| |  |  |  | | --- | --- | --- | | **Diagnosis at Intake**  DSM-IV Codes  DSM 5 Code  ICD-9 Codes  ICD-10 Codes | | | | **Check Primary/Billing Diagnosis** | **Code** | **Narrative Description** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | |  |  |  | | --- | --- | --- | | **Diagnosis at Discharge/Transition**  DSM-IV Codes  DSM 5 Code  ICD-9 Codes  ICD-10 Codes | | | | **Check Primary/Billing Diagnosis** | **Code** | **Narrative Description** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |

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| **Person’s Name** (First / MI / Last): | **Record#:** |

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| **Reason for Discharge or Transition:** | |
| Decrease level of care  Increase level of care  Goals met, no services needed  Person terminated services  Person refused referral for other services | Involuntary discharge, person informed of right to appeal  Person died  Person moved  Person did not return/was non-responsive to outreach attempts  Other: |

|  |
| --- |
| If involuntary/administratively discharged, summary of action taken: :  Not applicable Person Served notified of appeal process  Yes  No (explain) |

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| --- |
| Person’s Response to Treatment and Discharge/Transition: |

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| --- | --- | --- | --- |
| Medications as Reported by Person at time of Discharge/Transition:  None Reported | | | |
| **Medication Name** | **Dose** | **Plans for Change - Including Rate of Detox** | **Prescribed by** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |

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| --- | --- | --- |
| **Referred To (Agency/Program Name, Location, and Contact Information):** | **For (describe services/supports, rationale, list dates/times of appointments if known):** | **Date(s)/Time(s) of Appts. If Known:** |
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| **Aftercare Plan and Options** (Include information on symptoms person should watch for, options available if these symptoms recur, additional services needed, and/or follow-up plans): |

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| **Person’s Name** (First / MI / Last): | **Record#:** |

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| --- | --- | --- | --- |
| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | Was person provided copy of Discharge/Transition Plan? Yes, person given copy  Yes, Person mailed copy  No, person did not receive copy (explain): | |