**San Diego County Mental Health Services**

**CSU Episode Summary**

**\*Client Name:**      **\*Case #:**

**\*Discharge Date:**       **\*Program Name:**

\*Date of admission:

\*Mode of arrival: Choose an item.

 If Law Enforcement was selected, please specify: Choose an item.

\*Insurance? [ ]  No [ ]  Yes [ ]  Unknown

(If Yes, check all that apply)

 [ ]  Medi-Cal

 [ ]  Medicare

 [ ]  Private Insurance/ VA/ Tricare

\*Legal Status upon Admission:

 [ ]  Voluntary [ ]  72 Hour Hold for Adults [ ]  72 Hour Hold of Minors

[ ]  First 14 Day Hold [ ]  Second 14 Day Hold [ ]  Additional 30 Day Hold

[ ]  Additional 180 Day Hold [ ]  Other Involuntary Civil Status

[ ]  Charges/Convictions Pending [ ]  Incompetent to Stand Trial

[ ]  Not Guilty By Reason-Insanity [ ]  Sexual Psychopathy

[ ]  Transfer Correction Facility [ ]  Other Involuntary Criminal

[ ]  Petition for Evaluation [ ]  Conservatorship

Did client’s legal status change post-admission: [ ]  Yes [ ]  No; If yes, indicate change:

**\*REASON FOR ADMISSION**  *(Describe events in sequence leading to admission to your program. Describe primary complaint upon admission. Summary of client’s request for services including client’s most recent baseline. Include measurable and observable impairment behaviors. Mental Status at time of admission. Previous treatment, if known.)*

**COURSE OF TREATMENT**

\*Discharge Reason: Choose an item.

If Other, explain:

\*Discharge Destination: Choose an item.

 \*If Other, explain:

\*Upon Discharge, is client Homeless? [ ]  Yes [ ]  No

\*Upon discharge, what was client’s mode of transportation: Choose an item.

 If Other, explain:

Summary of Services:  *Response to treatment/progress, and reason for discharge, including healing and health services. Include any cultural considerations during the course of treatment.*

[ ]  Care Coordination with MH Provider [ ]  Care Coordination with PCP

[ ]  Psychiatric Evaluation [ ]  Risk Assessment [ ]  Medications Administered

[ ]  Family Counseling [ ]  Individual Counseling [ ]  Group Therapy

[ ]  Psychoeducation on Coping Skills [ ]  Safety Planning

[ ]  Case Management Services [ ]  Recreational Activities [ ]  Placement Assistance

[ ]  Socialization with Peers

For any box checked above, please describe client’s progress/level of participation:

Aftercare Plan:  *Information provided to client/family at discharge and recommendations, appointments, discharge location, substance use treatment recommendations.*

**MEDICAL HISTORY:**

Psychiatric Medications at Discharge (if possible, include dosage and frequency of medication; indicate if medications were given in-hand or prescription):

 Allergies and adverse medication reactions: [ ]  No [ ]  Unknown/Not Reported [ ]  Yes

 If yes, specify:

 Other prescription medications: [ ]  None [ ]  Yes [ ]  Unknown

 If yes, specify:

**HISTORY OF VIOLENCE**:

History of domestic violence: [ ]  None reported [ ]  Yes

History of significant property destruction: [ ]  None reported [ ]  Yes

History of violence: [ ]  None reported [ ]  Yes

*Specify type, intensity, and if past or current*.

History of abuse: [ ]  None reported [ ]  Yes

*Specify type, intensity, and if past or current.*

Abuse reported: [ ]  N/A [ ]  No [ ]  Yes

If Yes, specify:

\*Experience of traumatic event[s]:

[ ]  No [ ]  Yes [ ]  Unknown/not reported

If Yes: *Describe traumatic experience and summarize impact**.*

**REFERRAL(S)**: *Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.*

\*Referred to: Choose an item.

If Other, Specify:

Appointment Date:       Time:

[ ]  Client or caregiver declined referral(s)

**Signature of Clinician Requiring Co-signature**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary**