**San Diego County Mental Health Services**

**DISCHARGE SUMMARY**

**\*Client Name:**      **\*Case #:**

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

\*Date of admission:

**\*REASON FOR ADMISSION**  *Describe events in sequence leading to admission to your program. Describe primary complaint upon admission.*

**COURSE OF TREATMENT**

If the client has not met at least 50% of the treatment goals (including leaving treatment prior to completing goals), select NO. If the client has met all goals, select YES. If the client has met at least 50% of goals, select PARTIALLY.

\*Treatment goal(s) were met?

[ ]  No [ ]  Yes [ ]  Partially [ ]  No Plan Established

Discharge Reason: Choose an item.

Discharge Destination: Choose an item.

 If Other, explain:

 Significant diagnostic changes during treatment: [ ]  No [ ]  Yes

Summary of Services:  *Response to treatment/progress, and reason for discharge.*

Aftercare Plan:  *Information provided to client/family at discharge and recommendations.*

Housing/Living arrangements at discharge: *(Select from Living Arrangement table in Drop Down menu)*

Substance use treatment recommendations: [ ]  Not Applicable [ ]  Yes

**MEDICAL HISTORY:**

 Medications at Discharge:

Medication Adherence [ ]  Always [ ]  Sometimes [ ]  Rarely [ ]  Never [ ]  Unknown

 Comments:

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

 If yes, specify:

 Other prescription medications: [ ]  None [ ]  Yes

 If yes, specify:

 Herbal/Dietary Supplements/over the counter medications: [ ]  None [ ]  Yes

 If yes, specify:

 Healing and Health:

**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: [ ]  ACL, 211. Or Other Community Support [ ]  Act Program [ ]  CAPS [ ]  Case Management Program [ ]  Clubhouse [ ]  FFS Hospital [ ]  FFS Individual Provider [ ]  Mental Health Res Treatment Facility [ ]  OP Clinic [ ]  PEI Program [ ]  SDCPH [ ]  START (Crisis House) [ ]  Substance Abuse Treatment - OP [ ]  Substance Use Treatment – Residential [ ]  TBS [ ]  Other [ ]  Managed Care Plan - PCP [ ]  Managed Care Plan – MH Provider [ ]  FQHC

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**