Discharge Summary/Plan

The Discharge Summary/Plan is designed to encapsulate the course of treatment, outcomes, reasons for discharge, and plans for discharge. It is to be completed in accordance with program requirements.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record #, and D.O.B. must be completed on each page)
Individual's Name:	Record the first name, last name, and middle initial of the Individual served.
Record #:	If applicable, record your agency's identification number for the Individual served.
D.O.B:	Document Individual's date of birth.
Program Name:	Document the name of the program that the Individual served has been discharged from.
Admission Date:	Document the date the Individual served was admitted.
Last Contact:	Document the last date of contact with the Individual served.
Discharge Date:	Document the date that the Individual served is discharged.
Legal Status:	If the Individual served has legal status involvement at the time of discharge, check the appropriate box and provide details. Check if N/A.
Data Field	**Reason for Discharge Instructions**
Reason for Discharge:	Check to indicate reason(s) for discharge. Provide further information to justify/explain reason for discharge.
Data Field	**Summary of Treatment Instructions**
Summary of Services/Treatment Provided:	Provide a narrative summary of the Individual's presenting issues, services and treatment that were provided.
Outcomes:	Summarize progress on all goals/objectives since admission. Include the Individual's current level of functioning and any significant bio-psychosocial changes since his/her admission.
Strengths, abilities, preferences of Individual at time of discharge:	Include information regarding the Individual's strengths, abilities and preferences.
Sobriety Status:	Indicate Individual's current sobriety status and ongoing support system. If Individual served is not sober, detail current use. Check N/A if no history of substance use/abuse.

Data Field	Collaterals/ Providers Involved Instructions
List the collateral and/or providers involved during the course of treatment	Document all collateral and/or providers (outside of the current program) that have been involved with the IAP. If there is not any other collateral and/or providers involved, check the box none involved.
Data Field	**Diagnosis Instructions**
Axes I – V:	Spaces are provided to capture the information at time of discharge. Indicate Axes I-V from most recent psychiatric evaluation. Indicate the diagnostic code and conditions for Axes I – III according to the instructions from the diagnostic manual being used. For Axis IV, include the relevant categories of psychosocial or environmental problems/stressors as indicated in the evaluation. For Axis V, log the GAF score from the most recent psychiatric evaluation.
Data Field	**Referrals Instructions**
If no referrals were made, provide reason:	If no referrals were made, provide reason, e.g., Individual served voluntarily left without informing others, etc.
Referred To:	List all internal and external services/programs to which the Individual served is being referred at the point of discharge. This includes referrals made by additional providers. Specify agency/program name, location, and any other contact information the Individual served or parent/guardian/other will need to ensure continuity of care.
For:	Specify the types of services or programs, or reason why the Individual served is being referred for each particular listing.
Date(s)/Time(s) of Appointments:	Indicate any specific dates and/or times of appointments that have been set up for the Individual served.
Aftercare and Resource Options:	Indicate information on symptoms; including early warning signs / indications of relapse the individual should watch for, options available if these symptoms recur, or additional services needed and individual/community resources available to the Individual served and/or family and significant others.
For Applicable OASAS programs only, Substance Abuse Relapse Prevention Plan must be included. This does not apply to Methadone Maintenance Programs.	Individual served will list his/her personal relapse concerns and then identify strategies / resources he/she could use to help manage those concerns (e.g. Loneliness: “I will call someone in my support group when I feel lonely”). The completed individualized Substance Abuse Relapse Prevention Plan must be documented in the Discharge Summary/Plan.
Data Field	**Medications Instructions**
Medications (including OTC) at time of Discharge:	List medication name, dose, and frequency. Record the name of the prescriber as reported by the individual at the time of discharge. List the number of pills for each medication given to individual at the time of discharge. Also, indicate all prescriptions (RX) given at time of discharge. Check box if None Reported.
Data Field	**Financial Status Instructions**
Financial Status:	Indicate the current benefit status and/or the monies returned to the Individual served at the time of discharge if applicable.

Data Field	Individual Response & Participation/Copy Instructions
Individual's response in his/her own words to Discharge Plan:	Document Individual's response to discharge.
I have participated in the development of this plan or I was provided a copy of the plan: **Individual's Signature/Date:**	Indicate either Yes or No that the Individual served has participated in the development of the Discharge Summary/Plan. Indicate either Yes or No that the Individual served has received a copy of the Discharge Summary/Plan. Individual's signature and date reflects his/her participation in the development of the plan. If the Individual served does not sign or receive a copy of the Discharge Summary/Plan, list the reason.
Data Field	**Staff Signatures Instructions**
Print Parent/Guardian/Other Name:	The parent/guardian/other signature is necessary if Individual served is a minor or an adult who has a legal guardian. This space can also be used for any family/significant other as defined by the Individual served if he/she wishes them involved in process. Check if N/A.
Date:	Date of this signature.
Print Staff Name/Credentials:	**Legibly** record signature and credentials, according to agency policy, of the staff who prepared the Discharge Summary/Plan.
Date:	Date of this signature.
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials	If applicable, **legibly** record signature and credentials of supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.