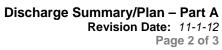








| Organization Name: | | | Program Name: | | | | | |
|---|---|---|---|--------------------------|------------------|--|--|--|
| Individ | ual's Name (First / MI / Last): | | Record #: | | DOB: | | | |
| Admiss | sion Date: | Last Contact: | | Discharge Date: | | | | |
| ☐ Inca | Legal Status − □ Not applicable □ Incarcerated □ Court Ordered Treatment □ Probation □ Parole □ Other: Legal Status Details: | | | | | | | |
| | Reason fo | or Discharge/Dis | sposition (Select | One):: | | | | |
| ☐ Furth☐ Left a☐ Left a☐ Left a☐ Disch☐ Disch☐ | onal treatment at this level of care no longer of treatment at this level unlikely to yield addengainst clinical advice: Formal referral made/orgainst clinical advice: Lost to contact (no refergainst clinical advice: Termination of third paraged due to non-compliance with program rearged due to regulatory requirements (note: care | d clinical gains offered erral possible) rty funds ules | ☐ Individual arrested/incarcerated ☐ Individual could no longer participate for medical/psych. reasons ☐ Individual death ☐ Individual relocated ☐ Program closed ☐ Other (OMH Only-describe below) | | | | | |
| Additio | nal Comments (Specify brief details): | | | | | | | |
| | | | | | | | | |
| Summa | ary of Services/Treatment Provided, In | cluding Reason for | Admission: | | | | | |
| | | | | | | | | |
| | nes (Summarize progress on ALL goals | | | unctioning including sol | briety status as | | | |
| applicable; and any significant bio-psychosocial changes since last admission): Strengths, abilities, preferences of Individual at time of discharge (For OMH Housing Programs for Children and Adolescents, Include Goals to Strengthen Success after Discharge): | | | | | | | | |
| | | | | | | | | |
| Living Arrangements and Vocational/Employment/Educational Status | | | | | | | | |
| Identify | Living Arrangements (OASAS Outpa | | | | | | | |
| | | | | | | | | |
| λ | Assessment of the home environme | nt and suitability of | housing (Residenti | al): | | | | |
| OASAS Only | Vocational/Employment/Educational | Status: | | | | | | |
| List the collateral and/or providers involved during the course of treatment: None Involved | | | | | | | | |
| | Agency/Name: | R | elationship | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

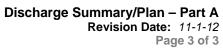








| Organization Name: | | | | Program Name: | | | | |
|--|--------------|---------------------|-----------------------------------|--|----------------------|--|--|--|
| Individual's | Name (Firs | t / MI / Last): | | Record #: | | DOB: | | |
| Diagnosis At Discharge | | | | | | | | |
| Check Primary | Axis | Code | Narrative Description | | | | | |
| | Axis I | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Axis II | | | | | | | |
| | | | | | | | | |
| | Axis III | | | | | | | |
| | Axis IV | | | | | | | |
| | Axis V | Current GAF: | | | | | | |
| Referrals | | | | | | | | |
| | | de, provide reason | : | | | | | |
| Referred To (Agency/Program Name, Location, and Contact Information): | | | For (describe services/supports): | | | Date(s)/Time(s) of Appts.: | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Relapse Prevention Plan | | | | | | | | |
| Information on symptoms Individual should watch for and options available if these symptoms recur: | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Aftercare and Resource Options Existing and/or additional services needed and community resources available to the individual and/or family and significant | | | | | | | | |
| others: | aror additio | nai sci vices necue | a and community reso | aroes available to the in- | arviduai arra/or iar | my and significant | | |
| | | | | | | | | |
| * OASAS Programs must complete the Discharge Summary Part B | | | | | | | | |
| | М | edications, Includi | ng Over the Counter, a | | Prescribed /Given | | | |
| Medication Name | | Name | Dose/ Frequency | Amount of Pills Given/ and date, if applicable | RX Given | If RX Given, Date of Last Prescription | | |
| 1 | | | | / | ☐ No ☐ Yes | | | |
| 2 | | | | 1 | ☐ No ☐ Yes | | | |
| 3 | | | | 1 | ☐ No ☐ Yes | | | |
| 4 | | | | / | ☐ No ☐ Yes | | | |









| Organization Name: | | Program Name: | | | |
|--|----------------------|----------------------------------|------------|-------|--|
| Individual's Name (First / MI / Last): | | Record #: | | DOB: | |
| 5 | | / | ☐ No ☐ Yes | | |
| 6 | | / | ☐ No ☐ Yes | | |
| 7 | | / | ☐ No ☐ Yes | | |
| 8 | | / | ☐ No ☐ Yes | | |
| 9 | | / | ☐ No ☐ Yes | | |
| 10 | | / | ☐ No ☐ Yes | | |
| 11 | | / | ☐ No ☐ Yes | | |
| 12 | | / | ☐ No ☐ Yes | | |
| I have participated in the development of this pla I was provided a copy of the plan ☐ Yes ☐ No If No, Provide a Reason: Individual's Signature (Optional): | n ☐ Yes ☐ No | | | Date: | |
| Parent/Guardian/Other Name ☐ (N/A): | Parent/Guard | Parent/Guardian/Other Signature: | | | |
| If lacking signature of Individual/Parent/Guardian, pro | vide reason for non- | participation: | | | |
| Completed By - Print Staff Name/Credentials: | Staff Signatur | re: | | Date: | |
| Supervisor/ Professional Staff/ QHP/ Team Leader – Print Name/Credentials (N/A): Supervisor/ Professional Staff/ QHP/ Team Leader Signature: | | | Date: | | |