Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Admission Date:	**Last Contact:**	**Discharge Date:**

Legal Status – ☐ **Not applicable**
☐ **Incarcerated** ☐ **Court Ordered Treatment** ☐ **Probation** ☐ **Parole** ☐ **Other:**
Legal Status Details:

Reason for Discharge/Disposition (Select One)::

☐ Additional treatment at this level of care no longer necessary	☐ Individual arrested/incarcerated
☐ Further treatment at this level unlikely to yield added clinical gains	☐ Individual could no longer participate for medical/psych. reasons
☐ Left against clinical advice: Formal referral made/offered	☐ Individual death
☐ Left against clinical advice: Lost to contact (no referral possible)	☐ Individual relocated
☐ Left against clinical advice: Termination of third party funds	☐ Program closed
☐ Discharged due to non-compliance with program rules	☐ Other (OMH Only-describe below)
☐ Discharged due to regulatory requirements (note: crisis programs)	

Additional Comments (Specify brief details):

Summary of Services/Treatment Provided, Including Reason for Admission:

Outcomes (Summarize progress on **ALL** goals since admission; include current level of functioning including sobriety 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 Outpatient and OMH Residential):

OASAS Only

Assessment of the home environment and suitability of housing (Residential):

Vocational/Employment/Educational Status:

List the collateral and/or providers involved during the course of treatment: ☐ **None Involved**

Agency/Name:	**Relationship**

Organization Name:	**Program Name:**	
Individual's Name (First / 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

If no referrals were made, 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:

*** OASAS Programs must complete the Discharge Summary Part B**

Medications, Including Over the Counter, at Discharge ☐ NONE Prescribed /Given

Medication Name	Dose/ Frequency	Amount of Pills Given/ and date, if applicable	RX Given	If RX Given, Date of Last Prescription
1		/	☐ No ☐ Yes	
2		/	☐ No ☐ Yes	
3		/	☐ 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	

Financial/Benefit Status - ☐ **Not Applicable**

Individual's response in his/her own words to Discharge Plan*:*

I have participated in the development of this plan ☐ Yes ☐ No
I was provided a copy of the plan ☐ Yes ☐ No
If No, Provide a Reason:

Individual's Signature (Optional):	**Date:**

Parent/Guardian/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date**:

If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date**:
Supervisor/ Professional Staff/ QHP/ Team Leader – Print Name/Credentials ☐ (N/A)**:**	**Supervisor/ Professional Staff/ QHP/ Team Leader Signature**:	**Date**: