Discharge Plan

Date:

Client: DOB: Medicaid #:

Program Name:

Admission Date: Discharge Date: Last Contact:

Legal Status:

Diagnoses at discharge:

Medications at time of discharge:

Reason for Discharge:

Summary of Services/Treatment Provided:

Summarize progress on all goals objectives since admission:

Risk Status: HI/SI Safety Plan:

Strengths/Abilities of client at time of discharge:

Sobriety Status:

Relapse Prevention Plan:

List Providers involved in treatment:

Referrals:

Referred to or why not:

Dates and times of appts:

Individual's Response in own words to Discharge plan: I have participated in the development of this plan and/or have been provided with a copy.

Client: _______________________________ Date: ________

Parent/Guardian: _____________________ Date: ________

Therapist: ____________________________ Date: ________

Supervising Practitioner: _______________ Date: ________

SAMPLE