**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 Client Plan 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.

\*Client Plan 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**