



<b>Organization Name:</b>		<b>Program Name:</b>	
<b>Individual's Name</b> (First / MI / Last):		<b>Record #:</b>	<b>DOB:</b>
<b>Admission Date:</b>	<b>Last Contact:</b>	<b>Discharge Date:</b>	
<b>Legal Status</b> – <input type="checkbox"/> <b>Not applicable</b> <input type="checkbox"/> <b>Incarcerated</b> <input type="checkbox"/> <b>Court Ordered Treatment</b> <input type="checkbox"/> <b>Probation</b> <input type="checkbox"/> <b>Parole</b> <input type="checkbox"/> <b>Other:</b> <b>Legal Status Details:</b>			
<b>Reason for Discharge:</b>			
<input type="checkbox"/> Completed Treatment: All Goals Met <input type="checkbox"/> Completed Treatment: Half or More Goals Met <input type="checkbox"/> Treatment Not Completed: Maximum Benefit/Clinical Discharge <input type="checkbox"/> Treatment Not Completed: Some Goals Met <input type="checkbox"/> Treatment Not Completed: No Goals Met <input type="checkbox"/> Additional treatment at this level of care no longer necessary <input type="checkbox"/> Further treatment at this level unlikely to yield added clinical gains <input type="checkbox"/> Left against clinical advice: Formal referral made/offered		<input type="checkbox"/> Left against clinical advice: Lost to contact (no referral possible) <input type="checkbox"/> Left against clinical advice: Termination of third party funds <input type="checkbox"/> Discharged due to non-compliance with program rules <input type="checkbox"/> Discharged due to regulatory requirements (note: crisis programs) <input type="checkbox"/> Individual arrested/incarcerated <input type="checkbox"/> Individual could no longer participate for medical/psych. reasons <input type="checkbox"/> Individual death <input type="checkbox"/> Individual relocated <input type="checkbox"/> Program closed	
<b>Additional Comments</b> (Specify brief details):			
<b>Summary of Services/Treatment Provided, Including Reason for Admission:</b>			
<b>Outcomes</b> (Summarize progress on <b>ALL</b> goals since admission; include current level of functioning including sobriety status as applicable; and any significant bio-psychosocial changes since last admission):			
<b>Strengths, abilities, preferences of Individual at time of discharge</b> (For OMH Housing Programs for Children and Adolescents, Include Goals to Strengthen Success after Discharge):			
<b>Living Arrangements and Vocational/Employment/Educational Status</b>			
<b>Identify Living Arrangements (OASAS Outpatient and OMH Residential):</b>			
<b>OASAS Only</b>	<b>Assessment of the home environment and suitability of housing (Residential):</b>		
	<b>Vocational/Employment/Educational Status:</b>		
List the collateral and/or providers involved during the course of treatment: <input type="checkbox"/> None Involved			
<b>Agency/Name:</b>		<b>Relationship</b>	



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**Diagnosis At Discharge**

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>	Axis IV		
<input type="checkbox"/>	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		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	



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5		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
6		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
7		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
8		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
9		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
10		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
11		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
12		/	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Financial/Benefit Status - <input type="checkbox"/> Not Applicable</b>				
<b>Individual's response in his/her own words to Discharge Plan:</b>				
I have participated in the development of this plan <input type="checkbox"/> Yes <input type="checkbox"/> No I was provided a copy of the plan <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Provide a Reason:				
<b>Individual's Signature (Optional):</b>				<b>Date:</b>
<b>Parent/Guardian/Other Name <input type="checkbox"/> (N/A):</b>		<b>Parent/Guardian/Other Signature:</b>		<b>Date:</b>
<b>If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:</b>				
<b>Completed By - Print Staff Name/Credentials:</b>		<b>Staff Signature:</b>		<b>Date:</b>
<b>Supervisor/ Professional Staff/ QHP/ Team Leader – Print Name/Credentials <input type="checkbox"/> (N/A):</b>		<b>Supervisor/ Professional Staff/ QHP/ Team Leader Signature:</b>		<b>Date:</b>