

Discharge / After Care Services

Patient: _____ DOB: _____ DOA: _____ DOD: _____

Discharge Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Psychiatrist/Physician: _____ Phone Number: _____
Therapist: _____ Phone Number: _____

Current Medications: See Attached Sheet

Specific Treatment Recommendations: _____

Reason for Discharge or Transfer to another Level of Care: _____

For Additional Clinical Information Please Contact the Medical Records Department at: _____

Referrals for follow up care by:	Address/Phone Number	Appointment Time & Date
<input type="checkbox"/> Psychiatrist:	_____	_____
<input type="checkbox"/> Psychologist/Counselor:	_____	_____
<input type="checkbox"/> Extended Inpatient Treatment @:	_____	_____
<input type="checkbox"/> Outpatient Treatment:	_____	_____
<input type="checkbox"/> Primary Physician:	_____	_____
<input type="checkbox"/> School Program @:	_____	_____
<input type="checkbox"/> Case Management:	_____	_____
<input type="checkbox"/> Financial:	_____	_____
<input type="checkbox"/> Employment/Vocational:	_____	_____
<input type="checkbox"/> Temporary Sponsor:	_____	_____
<input type="checkbox"/> Medical:	_____	_____
<input type="checkbox"/> Other:	_____	_____

Educational Information:

School Grade Level: _____ IEP: Yes or No
Contact _____ @ _____ for school records.

Living Arrangements Post Discharge:

Natural Home Therapeutic Foster Care Institution Other _____
Dietary Considerations: _____

Person Accepting Responsibility for Patient:

Parent(s) OJA DHS Other _____
Name: _____ Method of Transportation: _____

If you should become suicidal, homicidal or in a crisis situation, call _____ or go to the nearest Emergency Room.

_____ I understand prompt follow up care is critical to my (my child's) continued mental health recovery and I agree to take responsibility for keeping the scheduled appointment(s). In the event I must cancel these appointments, I further understand it is my responsibility to reschedule with the agency providing the aftercare services.

_____ I refuse to participate in any aftercare or case-management services.

Patient/ Parent/ Guardian: _____ **Date:** _____
Staff: _____ **Date:** _____

Faxed to: _____ Fax #: _____ Date: _____ Time: _____ Initials: _____