Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

☐ **Transition - From (Unit/Program):**	**To:**	
☐ **Discharge**		
Admission Date:	**Last Contact:**	**Transition/Discharge Date:**

Person's location and contact information post discharge/transition: **Address:** ☐ **Unknown**
Telephone: ☐ **Unknown**

Summary of Services/Treatment Provided/Status at Last Contact:

Outcomes (Include qualitative and quantitative information regarding progress/gains achieved, strengths, abilities and preferences. Specify any standardized measures used)**:**

Sobriety Status/Description of Current Drug or Alcohol Use: ☐ Not applicable

Status Towards Meeting Goals (NM=Not Met, PM=Partially Met, M=Met, D/C=Discontinued)

Goal #	Keyword	NM	PM	M	D/C	Comments
1. ☐		☐	☐	☐	☐	
2. ☐		☐	☐	☐	☐	
3. ☐		☐	☐	☐	☐	
4. ☐		☐	☐	☐	☐	
5. ☐		☐	☐	☐	☐	
6. ☐		☐	☐	☐	☐	
7. ☐		☐	☐	☐	☐	
8. ☐		☐	☐	☐	☐	

Overall Progress In Treatment:

Diagnosis At Intake				**Diagnosis At Discharge/Transfer**			
Check Primary	**Axis**	**Code**	**Narrative Description**	**Check Primary**	**Axis**	**Code**	**Narrative Description**
☐	Axis I			☐	Axis I		
☐				☐			
☐				☐			
☐	Axis II			☐	Axis II		
☐				☐			
☐	Axis III			☐	Axis III		
☐	Axis IV			☐	Axis IV		
☐	Axis V	GAF:		☐	Axis V	Current GAF:	
Lowest GAF in Past Year (If Known):				Highest GAF in Past Year (If Known):			

Reason for Transition or Discharge:

☐ Decrease level of care	☐ Involuntary discharge, person informed of right to appeal
☐ Increase level of care	☐ Person died
☐ Goals met, no services needed	☐ Person moved
☐ Person terminated services	☐ Person did not return/was non-responsive to outreach attempts
☐ Person refused referral for other services	☐ Other:

If involuntary/administratively discharged, summary of action taken: : ☐ **Not applicable**

Person Served notified of appeal process ☐ Yes ☐ No (explain)

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Person's Response to Treatment and Transition/Discharge:

Medications as Reported by Person at time of Transition/Discharge: ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			

Referred To (Agency/Program Name, Location, and Contact Information):	**For (describe services/supports, rationale, list dates/times of appointments if known):**	**Date(s)/Time(s) of Appts. If Known:**

Aftercare Options (Include information on symptoms person should watch for, options available if these symptoms recur or additional services needed):

Provider Signature/Credentials:	**Date:**	**Supervisor Signature /Credentials (**☐N/A**):**	**Date:**
Person Signature: **(Parents/Guardians Signature If Applicable)**	**Date:**	***Was person provided copy of Transition/Discharge Plan?*** ☐ Yes, person given copy ☐ Yes, Person mailed copy ☐ No, person did not receive copy (explain):	