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| Person’s Name (First MI Last):       | Record #:       | Date of Admission:       |
| Organization/Program Name:       | DOB:       | **Gender:** [ ]  Male [ ]  Female[ ]  Transgender |

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| [ ]  **Transition - From (Unit/Program):**  | **To:**  |
| [ ]  **Discharge**  |
| **Last Contact:**  | **Discharge/Transition Date:**  |

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| **Person’s location and contact information post discharge/transition: Address:** [ ]  **Unknown** **Telephone:** [ ]  **Unknown****If discharged to shelter document efforts to prevent**  |

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| **Strengths, Needs, Abilities and Preferences (S.N.A.P.) and Status at Last Contact:**      |

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| **Summary of Services/Treatment Provided** (consider vocational, educational, financial legal, medical, behavioral, and risk status): |

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

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| **Health and Safety Concerns (include behavioral, medical and/or substance use issues. Include risk of overdose):** [ ]  NA   |
| **This section mandatory for BSAS licensed services:****Describe the person’s current vocational, educational, and financial status:****Describe the person’s current legal problems:** [ ]  NA **Describe supports and services available to the person after discharge, provided by the licensee or by others:** |

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| **Status Towards Meeting Goals** (NM=Not Met, PM=Partially Met, M=Met, D/C=Discontinued) |
| **Goal #** | **Keyword** | NM | **PM** | M | **D/C** | **Comments** |
| 1. [ ]
 |       | [ ]  | [ ]  | [ ]  | [ ]  |       |
| 1. [ ]
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| **Overall Progress In Treatment:**  |

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| **Person’s Name** (First / MI / Last):  |  | **Record#:** |
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| **Diagnosis at Intake** **[ ]**  DSM-IV Codes **[ ]**  DSM 5 Code [ ]  ICD-9 Codes [ ]  ICD-10 Codes |
|  **Check Primary/Billing Diagnosis**  | **Code** | **Narrative Description**  |
| [ ]  |       |       |
|  [ ]  |       |       |
| [ ]  |       |       |
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| **Diagnosis at Discharge/Transition** **[ ]**  DSM-IV Codes **[ ]**  DSM 5 Code [ ]  ICD-9 Codes [ ]  ICD-10 Codes |
|  **Check Primary/Billing Diagnosis**  | **Code** | **Narrative Description**  |
| [ ]  |       |       |
| [ ]  |       |       |
| [ ]  |       |       |
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| **Reason for Discharge or Transition:** |
| [ ]  Decrease level of care[ ]  Increase level of care[ ]  Goals met, no services needed[ ]  Person terminated services[ ]  Person refused referral for other services | [ ]  Involuntary discharge, person informed of right to appeal[ ]  Person died[ ]  Person moved[ ]  Person did not return/was non-responsive to outreach attempts[ ]  Other: |

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| If involuntary/administratively discharged, summary of action taken: [ ]  Not applicable       Person Served notified of appeal process [ ]  Yes [ ]  No (explain)       |

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| Person’s Response to Treatment and Discharge/Transition:       |

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

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| **Person’s Name** (First / MI / Last):  | **Record#:** |
| **Referred To (Agency/Program Name, Location, and Contact Information):** | **For (describe recommended services/supports, rationale, list dates/times of appointments if known):** | **Date(s)/Time(s) of Appts. If Known:** |
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| **Aftercare Plan and Options** (Include information on symptoms person should watch for, options available if these symptoms recur, additional services needed, and/or follow-up plans):      |

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| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | Was person provided copy of Discharge/Transition Plan? [ ]  Yes, person given copy [ ]  Yes, Person mailed copy [ ]  No, person did not receive copy (explain):       |