Department of Children & Families

State Mental Health Facility Discharge Form

Instructions: This form will be faxed to the community case manager the day of discharge and to the medical service provider in jail, if appropriate. A copy of this form with the attachments will be mailed by the next working day.

Attach copies of Need/Issue Lists, Service Plan, current status, significant lab reports, physical exam (completed in last 30 days), attach copy of latest clinical summary/competency exam completed within 30 days prior to discharge, and comprehensive social history with latest update.

TO (Agency) _____

Phone # (_____) _____ Fax # (_____) _____

Mailing Address _____

_____

ATTN (Case Manager) _____ Phone # (_____) _____

A. Social Worker's Section: (Include all relevant demographic information)

1. Client's Name _____ Hospital Number _____

   Legal Status _____ Date of Admission (mm/dd/yyyy) _____/_____/_____

   Social Security Number _____ - _____ - _____ Date of Birth (mm/dd/yyyy) _____/_____/_____

   County of Residence _____ County of Admission _____

   Guardian or First Representative _____ Relationship _____

   Address _____

   Phone # (_____) _____

2. Discharged Status Including Conditional Release Plans: _____

   _____ _____ Discharge To _____

   Discharge Address _____

   Phone Number # (_____) _____

3. Financial Status: Type of Benefit(s) _____

   Name of Payee _____ Amount of Benefits _____

   Date Applied For _____/_____/_____ (mm/dd/yyyy) Date Accepted/Rejected _____/_____/_____ (mm/dd/yyyy) Appeals _____/_____/_____ (mm/dd/yyyy)

4. Who takes responsibility for the client upon discharge? (List name, relationship, responsibilities)

   _____ _____/_____/_____ Phone # (_____) _____

   Social Worker's Signature Date (mm/dd/yyyy)

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B. Psychiatrist's Section: Current Diagnoses (Current edition of DSM:

Course of Hospitalization:

1. Reason for Admission (Circumstances which brought client to hospital):

_____

_____

_____

_____

2. Assessment and Findings (Diagnostic assessments completed and findings including mental status exam):

_____

_____

_____

_____

3. Treatment and Response (Types, frequencies, and response from admission to present):

_____

_____

_____

_____

_____

4. Homicidal/Suicidal History (Address any issues related to these behaviors):

_____

_____

_____

5. Medication History for current admission, including any dosages, court ordered medications, significant labs for psychiatric management, (i.e., lithium levels, etc.), and side effects. (See also Medical Physician's section, page 3).

_____

_____

6. Prognosis including recommendations for follow up and early warning signs of decompensation (address delusional speech).

_____

_____

_____

_____ _____/_____/_____ Phone # (_____) _____

Psychiatrist's Signature Date (mm/dd/yyyy)

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C. Medical Physician's Section:

(summary of current hospital course as it relates to medical issues, note special consultations, need for follow up)

Allergies _____ Diet _____

Medical Diagnoses _____

_____

Lab and Other Studies including Pap Smear and Blood Levels appropriate for management of medical conditions.

_____

_____

_____

Immunizations: ☐ PPD ☐ DT ☐ Influenza ☐ Pneumovax

Hospital Course, Special Issues/Concerns, Recommendations for Follow-up (List some descriptive items such as important salient treatment modalities, special issues/concerns, successful treatment modalities):

_____

_____

_____

_____

_____

_____

Medication Regime including dosages, significant labs, and side effects. (See also Psychiatrist section page 2)

_____

_____

_____

_____

_____

_____

_____ _____/_____/_____ Phone # (_____) _____

Medical Physician's Signature Date (mm/dd/yyyy)

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D. Nurse's Section:

1. Adaptive Equipment: Indicate below if client has items listed or if client needs items listed.

☐ Has	☐ Needs	Dentures (Type) _____	☐ Has	☐ Needs	Hearing Aid
☐ Has	☐ Needs	Wheelchair	☐ Has	☐ Needs	Crutches
☐ Has	☐ Needs	Glasses	☐ Has	☐ Needs	Contacts
☐ Has	☐ Needs	Prosthesis _____	☐ Has	☐ Needs	Cane
☐ Has	☐ Needs	Walker			

2. Describe skin condition: _____

_____

_____

3. Is client at risk for choking? (check one) ☐ Yes ☐ No
   Does the attached Service Implementation Plan contain information related to prevention of aspiration? (check one)
   ☐ Yes ☐ No

4. Is client is on Blood/Body Fluid Precautions? (check one) ☐ Yes ☐ No

5. Side Effects/Adverse Reactions: _____

_____

_____

_____

6. Current Medications as ordered for separation (include date/time of last dose): _____

_____

_____

_____

_____

_____

   Number of days supply sent with client: _____

7. Medication not sent (per facility policy) _____

_____

_____

_____

_____

_____

8. Is client capable of taking his/her own medication? (check one) ☐ Yes ☐ No
   Has medication education been provided? (check one) ☐ Yes ☐ No

9. History of medication compliance while in hospital. ☐ Never ☐ Sometimes ☐ Usually ☐ Always

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D. Nurse's Section: (continued)

10. Summary of pertinent nursing information including recent changes in the physical condition/mental status and current weight, blood pressure, pulse/respiration, patterns of elimination, nutrition including feeding and eating habits and any special dietary needs (address choking risk), personal hygiene, menstrual cycle (as indicated) and identifying any nursing/individual needs and recommendations for nursing care plans.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____/_____/_____ Phone # (_____) _____
Nurse's Signature Date (mm/dd/yyyy)

Pre-Release Contacts (Nurse will notify the community agencies, or jail, regarding any relevant medical/nursing issues):

Person Contacted _____

Phone # (_____) _____ (_____) _____

FAX # (_____) _____ (_____) _____

Response _____

_____

_____

Nurse Making Contact _____ Date ____/____/_____ Time _____ am pm
(mm/dd/yyyy)

Phone # (_____) _____ Fax # (_____) _____

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E. Rehabilitation Section Instructions: Check (☐) the appropriate response.

Primary Language _____ ☐ Writes ☐ Speaks ☐ Signs

Secondary Language _____ ☐ Writes ☐ Speaks

Presently Attending Education: ☐ Yes ☐ No ☐ Reads ☐ Writes ☐ Counts ☐ Tells Time

Has completed: ☐ High School ☐ Vocational ☐ College

Interested in attending classes: ☐ High School ☐ Vocational ☐ College ☐ Graduate

Requires Therapeutic Devices: ☐ Glasses ☐ Hearing Aid

Behavioral Response Level

Language Skills ☐ Verbal ☐ Non-Verbal

Receptive Language (check one)
- ☐ Doesn't understand speech
- ☐ Understands simple conversation/instructions
- ☐ Understands complex conversation/instructions

Attention Span: ☐ 0-3 min. ☐ 4-9 min. ☐ 10+ min.

Expressive Language (check one)
- ☐ Makes no sounds
- ☐ Uses simple words
- ☐ Uses sentences
- ☐ Carries on conversation
- ☐ Other _____

Group Therapy Skills
- ☐ Likes Working in Group
- ☐ Expresses Feelings to Group
- ☐ Sets Goals for Self
- ☐ Speaks in Turn
- ☐ Responds to Feelings
- ☐ Identifies Interpersonal Barriers

Leisure Activities
- ☐ Initiates Leisure Activities
- ☐ Schedules Own Leisure Activities
- ☐ Selects Preferred Leisure Activities
- ☐ Participates in Offered Leisure Activities
- ☐ Invites Friends to Participate
- ☐ Evaluates Satisfaction

Social Skills (check all that apply)
- ☐ Expresses Feelings
- ☐ Expresses Affection Appropriately
- ☐ Initiates Conversations with Others
- ☐ Responds to Criticism (Pos/Neg)
- ☐ Converses About Family
- ☐ Compliments Others
- ☐ Offers Assistance
- ☐ Responds to Personal Statements
- ☐ Requests Assistance When Needed
- ☐ Expresses Opinions
- ☐ Asks Before Borrowing Items From Others
- ☐ Isolative
- ☐ Speaks in Normal Tone of Voice
- ☐ Boundary Issues (Personal Space)

Activity Preferences: (Mark boxes indicated by client)

☐ Arts/Crafts	☐ Parties/Programs	☐ Religious Services	☐ Music
☐ Horticulture	☐ Discussion Groups	☐ Exercising	☐ Outings
☐ Library	☐ Recreation	☐ Reading	☐ Movies
☐ Plays Sports	☐ Watches Sports		☐ Other _____

Past Employment (check): ☐ Sheltered Workshops ☐ Supported Employment ☐ Private Sector

Presently Employed With _____

Comments (recap client participation in Rehab. activities)_____

_____

_____ _____/_____/_____ Phone # (_____) _____

Rehab. Employee Signature Date (mm/dd/yyyy)

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F. Direct Care Section: Instructions: Place an **"I"** for **independent**, **"E"** for **needs encouragement** or **"A"** for **requires assistance**. In comment section, reflect on encouragement and assistance required.

Housekeeping:
___ Makes Beds
___ Operates Washer
___ Operates Dryer
___ Folds Clothes
___ Keeps room neat

Eating Habits:
___ Eats Breakfast, Lunch, and Dinner
___ Steals Food
___ Shares Food
___ Uses Good Table Manners
___ Follows Diet
___ Rate or Speed of Eating
___ Feeds Self Independently

Grooming:
___ Bathes
___ Dresses
___ Brushes Teeth
___ Washes Hair
___ Shaves
___ Grooms Hair
___ Wears Clean Clothes
___ Wears Appropriate Clothes
___ Uses Deodorant

Uses Telephone:
___ Local
___ Long Distance
___ Can Dial 911

Other:
___ Removes Items from Other's Rooms
___ Closes Bathroom Door
___ Flushes Toilet
___ Wash Hands after Using Rest Room
___ Washes Hands
___ Crosses Street Safely
___ Hoards Things
___ Dresses Appropriate to Season

Use of Tobacco Products:
___ Maintains a Schedule
___ Chain Smokes
___ Doesn't Smoke
___ Smokeless Tobacco Products

Budgets:
Spends $_____ Weekly
Spends ☐ Moderately ☐ Excessively on Snacks and Cigarettes
___ Can manage own money
___ Shops for Clothing
___ Saves Money
___ Saves for Leisure

Sexual Acting Out:
☐ Knowledge about
☐ Sexually Intruding on Others
☐ Exposing Self
☐ Public Masturbation
☐ Urinates in Public

Independent Living Clients Only
☐ Use of Transit Systems
☐ Develop a Budget
☐ Knows Food Safety Rules
☐ Knows Safety Rules for Kitchen
☐ Knows how to Evacuate in a Emergency
☐ Knows Items to Stock for Emergencies

Comments _____

_____

_____

_____

_____

_____

_____ _____/_____/_____Phone # (_____) _____
Direct Care Staff Signature Date (mm/dd/yyyy)

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G. Post Hospital Aftercare Recommendations by Service Team:

1. Check (□) indicates behavior as applicable to client:

Item	Previous History	Never	Sometimes	Often	Usually	Always
Violent to Self/Others/Property						
Suicidal						
Assaultive						
At Risk of Leaving						
Medication Compliance						
Therapeutic Activity Compliance						
Cooperative						
Demonstrates Understanding of Illness						
Has Supportive Family/Other						

2. List of circumstances under which relapse is apt to occur (early warning signs to look out for).

_____

_____

3. List crucial intervention needed to help promote successful placement (frequency of family contact, participation in AA, Day Treatment Group Therapy).

_____

_____

4. Description of the degree of supervision needed by the client. ☐ None ☐ Minimal ☐ Close
Comments (describe circumstances): _____

_____

5. Treatment Recommendations: _____

_____

_____

6. Client Preferences or Recommendations: _____

_____

_____

7. Appointment at Local Community Mental Health Agency Date _____/_____/_____ Time _____ am pm
(mm/dd/yyyy)
Name of Therapist _____ Appointment Confirmed By _____

8. Appointment for Medical Problems Date _____/_____/_____ Time _____ am pm
(mm/dd/yyyy)
Street Address _____

Physician's Name _____Phone # (_____) _____

Name of Person Responsible for Medical Treatment (including financially) _____

9. Additional Follow-up _____

_____ Date Signed ___/___/_____ Phone # (_____) _____
Service Team Leader or Designee (mm/dd/yyyy)

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H. Client's Copy of Discharge Summary: (To be completed with the client and assigned unit staff. A copy of this plan shall given to the client at the time of discharge).

Date: _____ Name: _____
(mm/dd/yyyy)
Hospital #: _____ SSN: _____

Legal Status: ☐ Voluntary ☐ Involuntary
☐ Competent ☐ Incompetent ☐ Incompetent to Proceed ☐ Not Guilty by Reason of Insanity
☐ Advance Directive ☐ Health Care Surrogate
Guardian: ☐ Person ☐ Property

This individualized discharge plan has been developed by:

_____ _____ _____
Staff Person Client Case Manager

Guardian's Name: _____ (_____)_____
Address Phone

Address _____

Provision for Placement: {For persons returning to jail, the following information is submitted for consideration in regards to potential placement and follow-up services.}
I will reside at: _____
Address

(_____)_____ _____
Phone # Contact Person

I understand the client rules are: _____

_____

I ☐ agree ☐ do not agree to abide by the rules. (Check one)

Family: My family ☐ has ☐ has not been notified of my discharge or ☐ has not been by my request.

They will assist me through _____

_____

Family was provided education on _____

Community Services Recommended	Available in Community	Recommended by Team	Agreed to by Client	Comments
Intensive Case Management				
Case Management				
Medical				
Substance Abuse				
Therapy				
Sheltered Employment				
Supported Employment				
Home Help				
Independent Living Skills Training				
Day Treatment				
Religious Services				
Financial				
Legal				
Educational				
Other (Specify):				

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H. Client's Copy of Discharge Summary:

Psychiatric Services: Psychiatric Services will be provided by Dr.: _____

Address: _____

Phone: (_____)_____ Contact Person: _____

My first appointment will be: Date: _____ Time: _____ am pm
(mm/dd/yyyy)

Medical Services: Provision of medical care will be provided by Dr.: _____

Address: _____

Phone: (_____)_____ Contact Person: _____

My special medical needs are: _____

Medication: My medications are for _____ dosage _____

I understand the importance of medication and agree to take it as prescribed. If I have problems, I will contact my case manager who is: _____ at (_____) _____

Financial: I will receive income of	Amount	Source
	$ _____	_____
	$ _____	_____

My cost of care will be $_____ I will receive for spending $_____

Transportation: Upon discharge, transportation will be provided by: _____

My daily transportation need to Dr. appointments, day treatment and recreational activities will be provided by _____.

Case Management Services: _____ will serve as my case manager. _____ will be my link to community services. I should let him/her know what my needs or concerns are. I will meet with him/her on (mm/dd/yyyy) _____ at _____ am pm for our first community visit at _____. He/She works for: _____.

Address: _____ Phone #: (_____)_____

Provision for State Hospital Follow Up & Continuity of Care: I will be on a _____ day leave of absence to ensure my adjustment and smooth transition into community living.

_____ will follow up with _____ phone calls and/or face to face visits.
Social Worker's Name Number/frequency

I may feel free to contact treatment team members during this transition. My treatment contacts are:

Names	**Phone #'s**
_____	(_____)_____
_____	(_____)_____

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Other Significant Information:

This treatment plan has been approved and agreed upon this _____ day of _____, _____
by affixed signatures:

_____ _____
Client Hospital Personnel

_____ _____
Case Manager Legal Guardian

Client did not agree to sign. Reason: _____

_____

_____

_____

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State Mental Health Facility Discharge Form (Page 12)

Client Name _____ Client ID#: _____ SS# _____

State Mental Health Facility Staff Person _____ Phone # _____

Signature _____ Date Discharge Packet Sent (mm/dd/yyyy)

This side to be completed by the State Mental Health Facility Staff Person and sent with discharge packet prior to discharge Check ☒ if included in packet or circle "NA"	This side to be completed by the Community Case Manager after receiving the discharge packet **Rating** Complete Info	Incomplete Info	No Info	**Notes** (Please Note Incomplete and/or Missing information Items) (Use Back if Necessary)
1. Form 7001 A. Social Worker's Section ☐ NA	3	2	1	
B. Psychiatrist's Section ☐ NA	3	2	1	
C. Medical Physician's Section ☐ NA	3	2	1	
D. Nurse's Section ☐ NA	3	2	1	
E. Rehabilitation Section ☐ NA	3	2	1	
F. Direct Care Section ☐ NA	3	2	1	
G. Post Hospital Aftercare ☐ NA	3	2	1	
H. Discharge Plan ☐ NA	3	2	1	
I. Attachments 1. Service Plan ☐ NA	3	2	1	
2. Court Orders ☐ NA	3	2	1	
3. Clinical Summaries ☐ NA	3	2	1	
4. Physical Exam ☐ NA	3	2	1	
5. Psychosocial History ☐ NA	3	2	1	
6. Other _____ ☐ NA	3	2	1	
7. Other _____ ☐ NA	3	2	1	
8. Other _____ ☐ NA	3	2	1	

2. Joint Review (of admission packet information) (Community Case Manger Completes)

A. Who Reviewed? State Mental Health Facility _____ Community Case Manager _____

B. When Reviewed? Dates(s) (mm/dd/yyyy) _____ _____

C. What incomplete/missing information items need to be resolved? (Use back if needed)

Above Item #	Action to Resolve	Who to Resolve	Date Due (mm/dd/yyyy)

3. Satisfaction of the Community Case Manager Please Circle Appropriate Rating	**Rating** Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	**Comments** (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)
A. Overall, I am very satisfied with the admission packet inoformation and process.	5	4	3	2	1	

B. Community Case Manager Signature _____ Phone # (_____) _____

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