

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 ____/____/____ Date Accepted/Rejected ____/____/____ Appeals ____/____/____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

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

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

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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).

Psychiatrist's Signature

_____/_____/_____
Date (mm/dd/yyyy)

Phone # (_____) _____

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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)

Medical Physician's Signature

_____/_____/_____
Date (mm/dd/yyyy)

Phone # (_____) _____

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CF-MH 7001, (July 2023) [65E-5.1303, F.A.C.]

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D. Nurse's Section:

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

<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Dentures (Type) _____	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Hearing Aid
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Wheelchair	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Crutches
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Glasses	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Contacts
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Prosthesis _____	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Cane
<input type="checkbox"/> Has	<input type="checkbox"/> 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)

- 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.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on its right side, suggesting it's resting on a surface.

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

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

Expressive Language (check one)

- ☐ Makes no sounds
- ☐ Uses simple words
- ☐ Uses sentences
- ☐ Carries on conversation
- ☐ Other _____

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

Group Therapy Skills

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

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)

Leisure Activities

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

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) _____

Rehab. Employee Signature

_____/_____/_____
Date (mm/dd/yyyy)

Phone # (____) _____

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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

Grooming:

- ☐ Bathes
- ☐ Dresses
- ☐ Brushes Teeth
- ☐ Washes Hair
- ☐ Shaves
- ☐ Grooms Hair
- ☐ Wears Clean Clothes
- ☐ Wears Appropriate Clothes
- ☐ Uses Deodorant

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

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

Uses Telephone:

- ☐ Local
- ☐ Long Distance
- ☐ Can Dial 911

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 _____

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

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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 # (____) _____
(mm/dd/yyyy)

Service Team Leader or Designee

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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 ☐ Incompetent to Proceed ☐ Not Guilty by Reason of Insanity
☐ Competent ☐ Incompetent
☐ 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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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		This side to be completed by the Community Case Manager after receiving the discharge packet					
		Rating			Notes (Please Note Incomplete and/or Missing information Items) (Use Back if Necessary)		
Check <input checked="" type="checkbox"/> if included in packet or circle "NA"		Complete Info	Incomplete Info	No Info			
1. Form 7001		3	2	1			
A. Social Worker's Section <input type="checkbox"/> NA							
B. Psychiatrist's Section <input type="checkbox"/> NA		3	2	1			
C. Medical Physician's Section <input type="checkbox"/> NA		3	2	1			
D. Nurse's Section <input type="checkbox"/> NA		3	2	1			
E. Rehabilitation Section <input type="checkbox"/> NA		3	2	1			
F. Direct Care Section <input type="checkbox"/> NA		3	2	1			
G. Post Hospital Aftercare <input type="checkbox"/> NA		3	2	1			
H. Discharge Plan <input type="checkbox"/> NA		3	2	1			
I. Attachments		3	2	1			
1. Service Plan <input type="checkbox"/> NA							
2. Court Orders <input type="checkbox"/> NA		3	2	1			
3. Clinical Summaries <input type="checkbox"/> NA		3	2	1			
4. Physical Exam <input type="checkbox"/> NA		3	2	1			
5. Psychosocial History <input type="checkbox"/> NA		3	2	1			
6. Other _____ <input type="checkbox"/> NA		3	2	1			
7. Other _____ <input type="checkbox"/> NA		3	2	1			
8. Other _____ <input type="checkbox"/> 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					Comments (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)
		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
A. Overall, I am very satisfied with the admission packet information and process.		5	4	3	2	1	
B. Community Case Manager Signature _____ Phone # (_____) _____							

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