

## Discharge Plan

<b>Date:</b>	
<b>Member Name:</b>	
<b>Member ID:</b>	
<b>Date of Birth:</b>	
<b>Level of Care at Discharge:</b>	
<b>Admit Date:</b>	
<b>Discharge Date:</b>	
<b>Last Contact Date:</b>	

Initial DSM Diagnoses:	Discharge Diagnoses:

Physical Health Conditions:

**Medicines (name, dose) at the time of discharge:**

Medicine Name	Dose	When	How

	Date medicines reviewed with member (or reason why not):
	Date medicines reviewed with referral (or reason why not):

**Services Used:**

Individual Therapy	Family Therapy
Group Therapy	Medicine Management
Home and Community Based Services (CPST/PSR/Peer Support)	
Evidence Based Practice (Identify here):	
Others (list any additional therapies):	

**Overall Status at discharge (Based on discharge diagnosis):**

Marked improvement	Moderate improvement	No change
Regressed	Unknown	

**Reason(s) for Discharge:**

Planned as scheduled	Referred for other services/change in Level of Care
Missed too many visits (if so, let Magellan know)	Member is leaving the area
Member stopped services	

**Summary of Services/Treatment Provided: (Progress on goals and objectives since admission)**

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**Current Risk Status (Danger of and/or harm to self or others):**

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**Strengths of client at time of discharge:**

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**Sobriety Status (if applicable):**

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**Relapse Prevention Plan**

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**Follow up/After Care:**

List all relevant referrals (can include Therapist, Doctors and Support Workers). If no after care appointments, why not?

Provider	Address	Phone #	Date	Time

**Does member agree to plan?**

	I helped in this plan and/or have a copy.
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**Crisis Plan:**

	A copy of my Crisis plan was given to me at time of discharge.
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**Signatures:**

Member:	Date:
Guardian:	Date:
Provider:	Date: