RECOVERY TECHNOLOGY L.L.C.

Discharge/Transitional Summary-Plan

Client Name_____ **Case #**_____

Date of Admission_____ **Date of Discharge**_____

Presenting Condition (according to the "Presenting condition" section of the Psychosocial Assessment that was completed upon admission)

Extent to which goals and objectives were met (according to the individual plans and progress reviews that were completed during treatment)

☐ Achieved major recovery goals ☐ Reached some of their goals ☐ Did not achieve established goals

Progress toward recovery or well-being/How did the client's life improve during treatment?
(This is based on a review of functioning at admission, the client's identified needs and goals, the level of goal achievement, and the level of functioning at discharge as compared to the level of functioning at admission)

Client Name_____ **Case #**_____

Strengths, Needs, Abilities, Preferences (Review this section of the Psychosocial Assessment and compare to the participants functioning at discharge. What changes have occurred in these areas as a result of treatment.)?

Services Provided:

☐ CSM ☐ BIP ☐ ACT/IDDT

☐ AIM ☐ OPT ☐ Psychiatric

Reason for discharge:

☐ Substantially all parts of the treatment plan or program were completed

☐ Dropped out of treatment

☐ Terminated by facility

☐ Transferring to another level of care, program, or facility

☐ Incarcerated or released by or to courts

☐ Death

☐ Other (Includes aging out of children's MH system, extended placement (conditional release) and all other reasons)

☐ Discharged from the state hospital to an acute medical facility for medical services (MH only)

☐ Not applicable (used for Update records only)

Status of client at Discharge:

☐ Presenting condition greatly improved

☐ Presenting condition moderately improved

☐ Presenting condition slightly improved

☐ Presenting Condition not improved

☐ Presenting Condition has worsened

☐ Unknown

Client Name_____ **Case #**_____

Recommended Support Systems and Services that will support continued recovery or well-being:

Person/Agency	Location/Address	Phone Number	Contact Person	First (or next) Appt.

Medications at discharge:

Discharge Diagnosis:

Primary_____

Secondary _____

Tertiary _____

Quaternary _____

Quinary_____

Senary _____

Septenary _____

Discharge/Transition Summary completed by:

_____ _____ _____

Name Credentials Date

_____

Supervisor Signature