Form # 112

PIEDMONT COMMUNITY SERVICES

Rev:12/3/2003

Transfer / Discharge Summary

Account Identification

Consumer's Full Name: ______________________________ Acct #: ______________ SSN: ______________

Transfer / Discharge

Admission Date: ______________ Last Service Date: ______________

Check One
- ☐ Discharge Date: ______________
- ☐ Transfer Date: ______________
  to: ______________________________

Presenting Problems: ______________________________

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Referral Made to Clinician / Program: ______________________________

Reason for Referral: ______________________________

Services Provided (Check all that apply)

- ☐ Behavioral Specialist
- ☐ Case Management / MH
- ☐ Case Management / MR
- ☐ Case Management / SA
- ☐ Clean Start
- ☐ Detoxification
- ☐ Dual Diagnosis Services
- ☐ Emergency Services
- ☐ Emergency Services (EAP)
- ☐ Family Therapy
- ☐ GAF at Admission __________
- ☐ GAF at Discharge __________
- ☐ Group Homes
- ☐ Intensive In-Home
- ☐ Intensive SA Services
  New Beginnings/Crossroads
- ☐ Med Maintenance
- ☐ Mental Health Specialist Services
- ☐ MH Support
- ☐ Outpatient Therapy / MH
- ☐ Outpatient Therapy / SA
- ☐ Parenting
- ☐ Psychiatric Services
- ☐ Psychosocial Services
- ☐ Psychosocial Rehab./Horizons
- ☐ Residential
- ☐ Supportive Living In-Home
- ☐ Specialized Group Therapy
- ☐ Second Chances
- ☐ VOCA
- ☐ Waiver Services
- ☐ Other: (Please specify)

Goal Addressed and Progress Per Integrated Service Plan

Goal ________	Goal ________	Goal ________	Goal ________	Goal ________
☐ Met	☐ Met	☐ Met	☐ Met	☐ Met
☐ Patrially Met	☐ Patrially Met	☐ Patrially Met	☐ Patrially Met	☐ Patrially Met
☐ Not Met	☐ Not Met	☐ Not Met	☐ Not Met	☐ Not Met
☐ Discontinued	☐ Discontinued	☐ Discontinued	☐ Discontinued	☐ Discontinued
☐ Not Developed (intake or crisis only)	☐ Not Developed (intake or crisis only)	☐ Not Developed (intake or crisis only)	☐ Not Developed (intake or crisis only)	☐ Not Developed (intake or crisis only)

Additional comments regarding client's progress as is relates to ITP: ______________________________

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Overall progress in treatment: ☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse

	ICD-9 Code	Diagnosis at Discharge/Transfer
Axis I (primary)		
Axis I (secondary)		
Axis I (tertiary)		
Axis II		
Axis III		
Axis IV		

Axis V (GAF) At Admission: ☐ At Transfer/Discharge: ☐

Indicate Medications on Transfer / Discharge

Medication	Dosage	Comment

Reason for Transfer / Discharge

- [ ] Left against advice
- [ ] Completed Treatment
- [ ] Other
- [ ] Jail / Detention
- [ ] Staff Decision
- [ ] Death of Client
- [ ] Transfer / referral - private
- [ ] Mutual staff / client decision
- [ ] Client relocated
- [ ] Intake Only

Condition on transfer / discharge:

- [ ] Worse
- [ ] No Change
- [ ] Much Improved
- [ ] Complete Remission
- [ ] Remission
- [ ] Recovered
- [ ] N/A

Upon Discharge - Referred To: (Check All That Apply)

- [ ] Agency Initiated
- [ ] Clergy
- [ ] Employer
- [ ] Jail / Prison
- [ ] Local Health Department
- [ ] Psychiatrist
- [ ] Hospital ER
- [ ] Self
- [ ] Primary Care Physician
- [ ] School
- [ ] Other Community Agency
- [ ] Vocational Rehab
- [ ] Other Physician
- [ ] Family and/or Friends
- [ ] Law Enforcement
- [ ] Hospital
- [ ] Other CMH Board
- [ ] Court
- [ ] Hospital / Inpatient
- [ ] Not Referred
- [ ] Other(specify) ____________________

Recommendations: (if applicable)

Plan for followup: (only for discharge)

Comments:

Consumer Signature ____________ Date ____________

Parent / Guardian Signature ____________ Date ____________

PCS Staff Representative ____________ Date ____________

Supervisor Signature ____________ Date ____________