Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone

Discharge Summary

Client Number:

Client Name:	**DOB:**	**Date:**
☐ **Client Deceased (a Critical Incident Report may be required, check with supervisor)**		
Does the client have a severe mental illness, as defined by Mainecare manual or is a Class Member? ☐Yes ☐No *If yes, you will need to follow SMI rules for discharging and may need permission to discharge client. (See SMI Termination Form)*		
Reason for Discharge		
Summary of Treatment (include course of treatment, progress or lack thereof towards meeting assessed needs, assess risk, goals & objectives)		
Medical Status at Admission & Discharge (please identify any significant changes)		
Mental Status at Admission & Discharge (please identify any significant changes)		
Recommendations and/or referrals for further continued service or after care needs or outcomes in relations to ITP/ISP (i.e., meds) Provider must have written plan or recommendations.		

Client Number:

What is the client's current living arrangement and vocational/employment status?

- ☐Assisted Living Facility
- ☐Community Residential Facility
- ☐Dorothea Dix
- ☐Foster Care
- ☐Homeless Shelter or on the Streets
- ☐Hospitalized for Medical Reasons
- ☐Incarcerated in a State Prison or County Jail
- ☐Nursing Home
- ☐Other Psychiatric Inpatient Unit or Facility
- ☐Own Apartment or Home
- ☐Residential Crisis Unit
- ☐Residential Treatment Facility (Group Home Arrangement)
- ☐Riverview Psychiatric Center
- ☐Supported Apartment
- ☐Temporarily staying with others
- ☐Clubhouse Transitional Employment
- ☐Competitively employed full-time (32 or more hours per week)
- ☐Competitively employed part-time (Less than 32 hours per week)
- ☐Not employed – looking for work
- ☐Not employed – not looking for work
- ☐Self-employed
- ☐Volunteer
- ☐Working with supports full-time (32 or more hours per week)
- ☐Working with supports part-time (Less than 32 hours per week

Discharge Disposition

- ☐Member deceased
- ☐Program's determination to discontinue services
- ☐Transfer
- ☐Comprehensive Transitional Care as required under BHHO/OHH
- ☐Treatment is complete and treatment goals are attained
- ☐Treatment is not complete and discharge is unplanned
- ☐Treatment is not complete but is a planned discharge

Diagnosis at Discharge (include ICD Code & Description)

Primary:

Secondary:

Transfer of Client (If transferring or discharging the client to another organization with an appropriate release.)

A copy of the Discharge Summary needs to be sent to:

Signature Section

Provider Signature	Date
Printed Name & Credentials	
Supervisor Signature (if applicable)	Date