Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

Discharge Summary

Client#

Client Name:	DOB:	Date:

☐ Client deceased (a Critical Incident Report may be required, check with supervisor)

Reason for Discharge:

Overview of Treatment:

Have ANY or ALL treatment goals been met? ☐ Yes ☐ No

Describe progress towards ITP/ISP goals & objectives or identify reasons for lack of progress:

Medical Status at Admission & Discharge

Please identify any significant changes from admission to discharge:

Mental Status at Admission & Discharge

Please identify any significant changes from admission to discharge:

Risk Assessment at time of Discharge: ☐ Not at risk (rated at 1) ☐ Yes, client at risk (rated 2-10)
If yes, please explain:

Recommendations and/or referrals for further continued service needs (i.e. meds): (Provider must have a written plan or recommendations.)

(Let the client know they can always seek mental health services. The client can always call crisis and warm line numbers if needed.)

Summary:

What is the client's current living arrangement? (the following is continued on the next page)

☐Assisted Living Facility
☐Community Residential Facility

Client#

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☐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

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

☐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)

Diagnosis at Discharge (include ICD code & description)

(Direct-Enter Providers please enter Diagnosis on the "diagnosis" tab in PIMSY)

Primary:

Secondary:

Stages of Change for Primary Dx: ☐Pre-contemplation ☐Contemplation ☐Preparation ☐Action ☐Maintenance ☐Termination ☐Not Applicable

Is patient a DMHMR class member? ☐ Yes ☐ No (If yes, attach Addendum to the Discharge Form)

Was this discharge planned by provider? ☐ Yes ☐ No

Please Explain:

Was this discharge completed by provider? ☐ Yes ☐ No

If no, please explain:

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