NORTH COUNTRY COMMUNITY MENTAL HEALTH

☐1 Discharge ☐2 Transfer: 3 From (Unit/Program) 4 To

5 Admission Date	6 Last Service Date	7 Discharge/Transfer Date
8 Presenting Concern(s):		

9 Services Provided (Check all that apply or enter # of visits per board policy)

☐Initial screening and referral
☐Individual children's counseling
☐Student assistance program
☐Home-based counseling
☐Individual adult counseling
☐Family counseling
☐Group counseling
☐Prevention
☐DD supports coordination
☐MI supports coordination
☐Nursing/health services
☐Registered dietician
☐Adult day treatment plan was discussed with the patient at length
☐Clubhouse
☐Employment services
☐WAC
☐Community activities
☐ACT
☐Residential services
☐Crisis services
☐Inpatient treatment plan was discussed with the patient at length
☐Psychiatric services
☐Diagnostic functional assessment
☐Physical therapy
☐Occupational therapy
☐Speech & hearing therapies
☐Detox.
☐Substance abuse counseling
☐Substance abuse IOP group
☐Aftercare group
☐Respite
☐Jail
☐Nursing home services
☐Other:

10 Outcome score at Admission: (Indicate score of applicable measure)
☐Basis-32 ☐CAFAS ☐NC-SNAP ☐Other

11 Outcome score at Discharge/Transfer: (Indicate score of applicable measure)
☐Basis-32 ☐CAFAS ☐NC-SNAP ☐Other

12 Goals/Supports addressed per PCP plan:

Goal/Sup	Goal/Sup	Goal/Sup	Goal/Sup	Goal/Sup
☐Met	☐Met	☐Met	☐Met	☐Met
☐Partially met	☐Partially met	☐Partially met	☐Partially met	☐Partially met
☐Not met	☐Not met	☐Not met	☐Not met	☐Not met
☐Discontinued	☐Discontinued	☐Discontinued	☐Discontinued	☐Discontinued

13 Overall progress in treatment: ☐Much improved ☐Somewhat improved ☐No change ☐Worse

14 Diagnostic Formulation:

	Principal	Code	Diagnosis at Discharge/Transfer
Axis I – Primary	☐		
Axis I – Secondary			
Axis II – Primary	☐		
Axis II – Secondary			
Axis III – Primary	☐		
Axis III - Secondary			
Axis IV – Psychosocial/Environmental Problem(s):			
Axis V -	**GAF/GAS at Admission**		**GAF/GAS at Discharge**

15 Medication on Discharge/Transfer:

16 Reasons for Discharge/Transfer:

Consumer Name	ID #	Date

DISCHARGE/TRANSFER/CONTINUITY OF CARE SUMMARY

☐01 Left against staff advice
☐02 Completed treatment
☐03 Other
☐04 Jail
☐05 Staff decision
☐06 Death of consumer
☐07 Transfer/referred private
☐08 Mutual staff/consumer decision
☐09 Consumer relocated
☐10 Intake only
☐11 Consumer choice

17 Condition on Discharge/Transfer (Comments)

☐Worse
☐No change
☐Improved
☐Much improved
☐Remission
☐Complete remission
☐Recovered
☐Unknown
☐Other

18 Reduction in service – Grievance and Appeals paperwork completed ☐**Yes** ☐**N/A**
19 Psychiatric consultation completed (for consumers on psychotropic medication) ☐**Yes** ☐**N/A**

20 Living arrangements at time of discharge/transfer:

☐01 Homeless
☐02 Living with natural or adoptive family members
☐03 Private residence alone or w/ spouse or non-relative
☐05 Foster family (Children's Foster Care)
☐06 Specialized residential Adult Foster Care home
☐08 General Adult Foster Care home
☐10 Prison/jail/juvenile detention
☐12 Nursing care facility
☐13 Institutional setting
☐16 Supported Independent Living Program

21 Continuity of Care

Transferred/Referred To:	**Responsible For Continuing Care**				
(Check all that apply)	**Self**	**Family/ Friends**	**Community**	**Public Agencies**	**CMH**
☐01 Agency initiated	☐	☐	☐	☐	☐
☐02 Self	☐	☐	☐	☐	☐
☐03 Family or friends	☐	☐	☐	☐	☐
☐04 Clergy	☐	☐	☐	☐	☐
☐05 Primary care physician	☐	☐	☐	☐	☐
☐06 Law enforcement	☐	☐	☐	☐	☐
☐07 Employer	☐	☐	☐	☐	☐
☐08 School	☐	☐	☐	☐	☐
☐09 Hospital	☐	☐	☐	☐	☐
☐10 Jail/prison	☐	☐	☐	☐	☐
☐11 Other community agency	☐	☐	☐	☐	☐
☐12 Other CMH Board	☐	☐	☐	☐	☐
☐13 Family Independence Agency	☐	☐	☐	☐	☐
☐14 Local Health Department	☐	☐	☐	☐	☐
☐15 Vocational Rehabilitation	☐	☐	☐	☐	☐
☐16 Court	☐	☐	☐	☐	☐
☐17 Other	☐	☐	☐	☐	☐
☐18 Other physician	☐	☐	☐	☐	☐
☐19 Not referred	☐	☐	☐	☐	☐
☐20 Psychiatrist	☐	☐	☐	☐	☐
☐21 Hospital/Inpatient	☐	☐	☐	☐	☐
☐22 Hospital ER	☐	☐	☐	☐	☐

22 Recommendations:

Consumer Name	**ID #**	**Date**

NORTH COUNTRY COMMUNITY MENTAL HEALTH

23 Consumer Satisfaction: On a scale of one to five, how satisfied is consumer with our services? Check one
☐Not very satisfied ☐Somewhat satisfied ☐Satisfied ☐Mostly satisfied ☐Very satisfied

Use direct quote from consumer:

24 Appointment date: (If applicable)	**Time**	**Location**

☐ **25 Consumer refused referral for further services**
☐ **26 Consumer given advance notice**
☐ **27 Consumer has received a copy of Discharge/Transfer/Continuity of Care Plan**

If at any time the staff of CMH can be of further assistance, please call:

Signatures:

Consumer Date Guardian Date

CMH Representative Date CMH Supervisor Date

CMH Representative Date Other Date

Other Date Other Date

Physician (If needed) **I order/prescribe/refer the above services as requested** Date

Start Time	**Stop Time**	**Duration**	**Location**	**Activity Code**	**Cost Center**

Consumer Name	**ID #**	**Date**