MENTAL HEALTH DISCHARGE SUMMARY

NAME (Offender): _____

AGENCY: _____

DATE: _____

1. DSM IV DIAGNOSIS: _____

2. REASONS FOR TERMINATION (CHECK ONE):

- ☐ SUCCESSFUL DISCHARGE
- ☐ UNSUCCESSFUL DISCHARGE
- ☐ INTERRUPTION OF TREATMENT

VENDOR COMMENTS

EXPLAIN (USE ADDITIONAL PAGES IF NEEDED):

_____

3. RECOMMENDATIONS FOR COMMUNITY BASED AFTERCARE:

_____

_____ _____

Signature of Counselor Date

Revised: 6/20/12