**TRANSITIONAL CARE PLAN**

|  |  |
| --- | --- |
| **Client Name:** Click here to enter text. | **PACTS No.** Click here to enter text. |
| **Provider Name:** Click here to enter text. | **Date:** Click here to enter a date. |

 **REASON FOR CONCLUSION OF TREATMENT:**

|  |  |
| --- | --- |
| [ ]  Successful Discharge | [ ]  Unsuccessful Discharge |
| [ ]  Interruption of Treatment (explain): Click here to enter text. |

 **DIAGNOSIS AND ACUITY:**

|  |
| --- |
| Click here to enter text. |

**PROGNOSIS:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Poor | [ ]  Fair | [ ]  Good  | [ ]  Excellent  |

**STAGE OF CHANGE:** (if applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Precontemplation | [ ]  Contemplation | [ ]  Preparation | [ ]  Action  | [ ]  Maintenance |

 **CLIENT SUPPORTIVE SOCIAL NETWORKS/FAMILY INVOLVEMENT:**

|  |
| --- |
| Click here to enter text. |

 **MEDICATION MANAGEMENT PLAN:** (when applicable, to include adherence to medication)

|  |
| --- |
| Click here to enter text. |

 **COLLABORATION/COORDINATION FOR TRANSITIONAL SERVICES:** (community resources)

|  |
| --- |
| Click here to enter text. |

 **ACQUIRED SKILLS FOR MANAGING RISK/SYMPTOMS AND SELF-MANAGEMENT:**

|  |
| --- |
| Click here to enter text. |

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

*A Transitional Care Plan, created with the client when possible, is submitted at the conclusion of services, but no later than 15 days prior to residential discharge or 15 days after outpatient treatment is terminated.*