TRANSITIONAL CARE PLAN

Client Name:	**PACTS No.**
Provider Name:	**Date:**

REASON FOR CONCLUSION OF TREATMENT:

☐ Successful Discharge	☐ Unsuccessful Discharge
☐ Interruption of Treatment (explain):	

DIAGNOSIS AND ACUITY:

PROGNOSIS:

☐ Poor	☐ Fair	☐ Good	☐ Excellent

STAGE OF CHANGE: (if applicable)

☐ Precontemplation	☐ Contemplation	☐ Preparation	☐ Action	☐ Maintenance

CLIENT SUPPORTIVE SOCIAL NETWORKS/FAMILY INVOLVEMENT:

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

COLLABORATION/COORDINATION FOR TRANSITIONAL SERVICES: (community resources)

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

Counselor Signature: _____ Date: _____

Client Signature: _____ 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.