Discharge Summary and Continuing Care Plan

Patient Name (print): _____

Date of birth: _____ / _____ / _____

Admission Date: _____ / _____ / _____

Discharge Date: _____ / _____ / _____

Program: Location:

Admission Diagnoses:

Strengths:

Needs:

Abilities:

Preferences:

Summary of treatment and progress made towards treatment goals:

Discharge Diagnoses:

Prognosis/Areas of Concern:

Discharge Medications:

Summary of Continuing Care Plan:

☐ Individual Therapy ☐ Family Therapy ☐ PHP ☐ Recovering(me)

☐ 12-Step Meetings ☐ Obtain a Sponsor ☐ IOP

☐ Halfway House ☐ Outpatient Clinic ☐ Group Therapy

Other: _____

Category of discharge location: Other: _____

Type of transportation: Other: _____

Primary source of income: Other: _____

MAT after discharge? ☐ yes ☐ no

If so, where? _____

Confirmed Appointments

Provider Name: _____

Appointment Date: _____ / _____ / _____

Address: _____

Provider Name: _____

Appointment Date: _____ / _____ / _____

Address: _____

Provider Name: _____

Appointment Date: _____ / _____ / _____

Address: _____

Completed Program? ☐ yes ☐ no

Patient Signature: _____ Date: _____ / _____ / _____

Team Member Signature: _____ Date: _____ / _____ / _____