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| --- | --- | --- |
| \*Complete discharge summary or closing note within 30 days from last date of service. Closing note/discharge summary should be completed even if client terminated prematurely. | | |
| Client Name: | | Date of Intake: |
| Discharge Diagnosis: | | Date of Discharge: |
| **Course of Treatment** | | |
| Referral Source/Reason for admission: |  | |
| Outcome (treatment objectives met?)  Yes  No  Partially  Client did not return |  | |
| Significant diagnostic changes during treatment?  Yes  No |  | |
| **Medication Information** | | |
| Medications at Discharge:  Medication Adherence:  Always  Sometimes  Rarely  Never  Unknown |  | |
| **Discharge Plans** | | |
| Recommendations/Referrals (*safety plan, follow-up activities*): |  | |
| If client was transferred to another program/provider, attempts were made to coordinate care, please describe: |  | |
| **Provider Information** | | |
| Provider Signature & Credentials (*if signature illegible, include printed name*): | | Date of Signature: |