**San Diego County Mental Health Services**

**Short-Term Residential Program (STRTP)**

**DISCHARGE SUMMARY**

**\*Client Name:** **\*Case #:**

**\*STRTP Name:** **\*Date of Admission:**

* STRTP Discharge Summary to be completed within 7 Calendar days after child or youth’s discharge from the STRTP and aftercare services (if applicable), and is a companion to the Transition Determination Plan*.*

**\*1. DISCHARGE DATE FROM STRTP PLACEMENT:** *not including aftercare provided by STRTP*:

**\*2. AFTERCARE PROVIDED BY THE STRTP:** [ ]  Yes [ ]  No

**\*3. DISCHARGE DATE FROM AFTERCARE:** *Include only if aftercare provided by STRTP*:       [ ]  N/A

**\*4. SUMMARY OF SERVICES PROVIDED DURING AFTERCARE:** *Only complete if aftercare services were provided.*

      [ ]  N/A

\*5. **DISCHARGE REASON:** Choose an item.

**\*6. DISCHARGE DESTINATION:** Choose an item.

**\*7. WERE THE CLIENT PLAN GOALS MET?**

[ ]  Yes [ ]  No [ ]  Partially [ ]  No Goals Established

**Signature of Clinician Requiring Co-signature**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**\*Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number: