



Discharge Form

NAME/MRN _____

Discharge Date _____

Facility Name _____ ID _____ Program Name _____ ID _____

Primary Service Provider _____ ID _____ Physician _____ ID _____

Legal Class at Discharge		
<input type="checkbox"/> P13700 Incompetent to Stand Trial	<input type="checkbox"/> W52600 Additional 14 Day Hold	<input type="checkbox"/> W55850 72 Hour Eval&Trtmnt Child
<input type="checkbox"/> P13720 Incompetent to Stand Trial	<input type="checkbox"/> W52700 Additional 30 Day Hold	<input type="checkbox"/> w60000 Voluntary
<input type="checkbox"/> U99999 Unknown/Not Reported	<input type="checkbox"/> W53000 Additional 180 Day Hold	<input type="checkbox"/> W65000 Judicial Commitment DD
<input type="checkbox"/> W51500 72 Hour Eval&Trtmnt Adult	<input type="checkbox"/> W53500 Temp Conservatorship	<input type="checkbox"/> W65500 Commitment of Minor DD Eval
<input type="checkbox"/> W52500 14 Day Intensive Treatment	<input type="checkbox"/> W53550 Perm Conservatorship	<input type="checkbox"/> W99998 Other Involuntary Civil

Residential Living Arrangement: (check one response)		
<input type="checkbox"/> Adult Residential Facility	<input type="checkbox"/> House or Apt. with Supervision	<input type="checkbox"/> Res Tx Cntr (Level 13-14 Child)
<input type="checkbox"/> Alcohol Abuse Facility	<input type="checkbox"/> House or Apt. with Support	<input type="checkbox"/> Satellite Housing
<input type="checkbox"/> Community Treatment Facility	<input type="checkbox"/> Inpatient Psychiatric / PHF	<input type="checkbox"/> Single Room
<input type="checkbox"/> Crisis Residential Facility	<input type="checkbox"/> Institute of Mental Disease (IMD)	<input type="checkbox"/> Small Board & Care
<input type="checkbox"/> Drug Abuse Facility	<input type="checkbox"/> Justice Related	<input type="checkbox"/> SNF/ICF
<input type="checkbox"/> Foster Family Home	<input type="checkbox"/> Large Board & Care	<input type="checkbox"/> SNF/ICF - Psych Reasons
<input type="checkbox"/> General Hospital	<input type="checkbox"/> Lives alone	<input type="checkbox"/> State Hospital
<input type="checkbox"/> Group Home (Level 1-12 Child)	<input type="checkbox"/> Lives with family	<input type="checkbox"/> Supported Housing
<input type="checkbox"/> Group Quarters	<input type="checkbox"/> Lives with others	<input type="checkbox"/> Temporary Arrangement
<input type="checkbox"/> Homeless - No Residence	<input type="checkbox"/> Lives with relatives	<input type="checkbox"/> Unknown / Not Reported
<input type="checkbox"/> Homeless, No Identifiable Residence	<input type="checkbox"/> MH Rehab Center (24 Hour)	<input type="checkbox"/> VA Hospital
<input type="checkbox"/> House or Apartment	<input type="checkbox"/> Other	

Substance Abuse or Dependence Issue <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown SA Diagnosis: _____		Employment Status: (check one response) <input type="checkbox"/> Full time, 35 hours or more per week (comp) <input type="checkbox"/> Part time, less than 35 hours per week (comp) <input type="checkbox"/> Homemaker, Not Seeking Work <input type="checkbox"/> Unemployed, actively looking for work <input type="checkbox"/> Other <input type="checkbox"/> Resident / Inmate of institution <input type="checkbox"/> Retired <input type="checkbox"/> Student, Full Time <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> Volunteer Worker	
Special Population: <input type="checkbox"/> Katie A <input type="checkbox"/> KTA-ICC (non-CFC)		<input type="checkbox"/> Disabled <input type="checkbox"/> Full time, 35 hours or more per week (non-comp) <input type="checkbox"/> Homemaker, Seeking Work <input type="checkbox"/> Part time, less than 35 hours per week (non-comp) <input type="checkbox"/> Student, Employed Part Time <input type="checkbox"/> Student, Part Time <input type="checkbox"/> Unemployed, not seeking work <input type="checkbox"/> Full-time training <input type="checkbox"/> Part-time training	
Discharge Reason: <input type="checkbox"/> Completed Tx/Goals Reached/Referred <input type="checkbox"/> Completed Tx/Goals Not Reached/Referred <input type="checkbox"/> Mutual Agreement - Treatment Goals partially met <input type="checkbox"/> Mutual Agreement - Treatment Goals Not Met <input type="checkbox"/> Client Withdrew, AWOL, AMA, TX goals partially met		<input type="checkbox"/> Client Withdrew, AWOL, AMA, No Improvement <input type="checkbox"/> Client Deceased <input type="checkbox"/> Client Moved Out of Area <input type="checkbox"/> Client incarcerated <input type="checkbox"/> Client Discharged, Administrative <input type="checkbox"/> Other	

Discharge Status:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Still a patient or expected to return | <input type="checkbox"/> Discharged/transferred to Community Treatment Facility (locked, no nursing care) | <input type="checkbox"/> Unplanned discharge | <input type="checkbox"/> Discharged/transferred to medical unit |
| <input type="checkbox"/> Discharged to home, self-care, foster care, shelter care | <input type="checkbox"/> Discharged/transferred to Skilled Nursing Facility/Intermediate Care Facility (unlocked or locked) | <input type="checkbox"/> Discharged/transferred to Jail | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Discharged/transferred to Residential/Board and Care (not locked, supervised living, no treatment) | <input type="checkbox"/> Discharged/transferred to Acute Care Hospital or Psychiatric Health Facility (PHF) | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Discharged/transferred to Community Residential Treatment (not locked, custodial) | <input type="checkbox"/> Discharged/transferred to State Hospital | <input type="checkbox"/> Unknown / Not Reported | |
| | | <input type="checkbox"/> Discharged or transferred to another short term hosp | |
| | | <input type="checkbox"/> Discharged or transferred another type of institution | |
| | | <input type="checkbox"/> Left against medical advice | |

Referred To: (may choose up to 3)

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> SELF | <input type="checkbox"/> CHILD PROTECTIVE SERVICES | <input type="checkbox"/> HEAD START PROGRAM | <input type="checkbox"/> MT DIABLO UNIFIED SCHOOL DIST | <input type="checkbox"/> ROOM & BOARD |
| <input type="checkbox"/> MENTAL HEALTH ACCESS LINE | <input type="checkbox"/> CHILDRENS GROUP HOME | <input type="checkbox"/> INPATIENT PSYCH - UNIT 4C | <input type="checkbox"/> MT DIABLO USD - WRAP SERVICES | <input type="checkbox"/> SAN RAMON REGIONAL MED CENTER |
| <input type="checkbox"/> POLICE | <input type="checkbox"/> CHILDREN'S MH SPECIALITY PRGM | <input type="checkbox"/> JAIL/JUVENILE HALL | <input type="checkbox"/> OTHER | <input type="checkbox"/> SCHOOL OR COLLEGE |
| <input type="checkbox"/> LOW FEE MENTAL HEALTH CLINIC | <input type="checkbox"/> COMMUNITY BASED ORGANIZATIONS | <input type="checkbox"/> JOHN MUIR MEDICAL CENTER | <input type="checkbox"/> OTHER PSYCHIATRIC HOSPITAL | <input type="checkbox"/> SHELTER - NON COUNTY |
| <input type="checkbox"/> FAMILY | <input type="checkbox"/> COUNTY HEALTH CLINICS | <input type="checkbox"/> JOHN SWETT SCHOOL DISTRICT | <input type="checkbox"/> OUT OF COUNTY - HOSPITAL | <input type="checkbox"/> SOCIAL SERVICES DEPT - EAST |
| <input type="checkbox"/> STAFF PROCEDURES | <input type="checkbox"/> DELTA MEMORIAL HOSPITAL | <input type="checkbox"/> JUVENILE HALL | <input type="checkbox"/> PATHWAYS TO WELLNESS-ADULT MED | <input type="checkbox"/> SUICIDE CRISIS PROGRAM |
| <input type="checkbox"/> MEDICAL EMERGENCY - MERRITHEW | <input type="checkbox"/> DEPT SOCIAL SERVICES - FOSTER | <input type="checkbox"/> KAISER | <input type="checkbox"/> PITTSBURG CLINIC ADULT OP UR | <input type="checkbox"/> TELECARE HOPE HOUSE CRISIS RES |
| <input type="checkbox"/> AMADOR INSTITUTE | <input type="checkbox"/> DETENTION MH-MTZ | <input type="checkbox"/> KATIE A | <input type="checkbox"/> PITTSBURG UNIFIED SCHOOL DIST | <input type="checkbox"/> TRANSITIONAL SERVICES |
| <input type="checkbox"/> ANKA BEHAVIORAL HS CRISIS RES | <input type="checkbox"/> DRUG ABUSE PROGRAM | <input type="checkbox"/> MARTINEZ CRISIS STABILIZATION | <input type="checkbox"/> PRIVATE PRACTICE (NON-MD) | <input type="checkbox"/> WEST CONTRA COSTA SCHOOL DIST |
| <input type="checkbox"/> ANKA CENTRAL FSP | <input type="checkbox"/> EARLY CHILDHOOD INFANT/PARENT | <input type="checkbox"/> MEDICAL INPATIENT | <input type="checkbox"/> PRIVATE PSYCHIATRIST | <input type="checkbox"/> WEST COUNTY ADULT - EL PORTAL |
| <input type="checkbox"/> BAY AREA COMMUNITY RESOURCES | <input type="checkbox"/> EARLY CHILDHOOD MH - OUTPATINT | <input type="checkbox"/> MEDICAL OUTPATIENT | <input type="checkbox"/> PROBATION DEPARTMENT | <input type="checkbox"/> WEST COUNTY CHILDREN SVC UR |
| <input type="checkbox"/> BOARD & CARE HOME NON-SB155 | <input type="checkbox"/> EAST COUNTY CHILDREN'S SVC UR | <input type="checkbox"/> MENTAL HEALTH CARE MGMT UNIT | <input type="checkbox"/> PSYCHIATRIC EMERGENCY/NON-CCC | <input type="checkbox"/> YOUTH SERVICES BUREAU |
| <input type="checkbox"/> CALIFORNIA SPECIALTY HOSPITAL | <input type="checkbox"/> FORENSIC AOT | <input type="checkbox"/> MILLER WELLNESS CNT | <input type="checkbox"/> PSYCHIATRIC OUTPATIENT | |
| <input type="checkbox"/> CENTRAL COUNTY ADULT OP UR | <input type="checkbox"/> FREMONT HOSPITAL | <input type="checkbox"/> MOBILE RESPONSE TEAM | <input type="checkbox"/> REFERRAL DATA MISSING/ NA | |
| <input type="checkbox"/> CENTRAL COUNTY CHILDREN SVC UR | | <input type="checkbox"/> MT DIABLO MEDICAL PAVILLION | | |

ICD-10 Code:**DSM5 Description:**

Begin Date:

Begin Time: 12:00 am

Diagnosis by:

ID

Signature/License/Job Title

Print Name/Licensure/Designation

Date

Co-Signature/License (if applicable)

Print Name/Licensure/Designation

Date

Data Entry Clerk Initials