

DISCHARGE SUMMARY

Client I.D. #: _____ Client Last Name _____ First Name _____ M.I. _____ Discharge Date: _____/_____/_____

DSM Diagnosis at Discharge:

Axis I: _____ Code #: _____
Axis I (Secondary): _____ Code #: _____
Axis II: _____ Code #: _____
Axis III: _____

Axis IV Problems: *(circle)*

Support group:	Yes	No	Health care access:	Yes	No	Occupational:	Yes	No
Educational	Yes	No	Other:	Yes	No	Economic:	Yes	No
Housing	Yes	No	Social Environment:	Yes	No	Legal system/crime:	Yes	No

Axis V: (Current GAF) _____ LOI: *(circle)* 1A 2A 3A
1B 2B 3B

Reason for Discharge:

Treatment Summary: *(Summary of services, clinical course and progress toward goals, use back of form if necessary)*

Medications/Medical Problems at Discharge:

Disposition, Recommendations and Arrangements for Further Services, Including Psychiatric Follow-up: *(Please document follow-up of referrals)*

Clinician's Signature

Date