Discharge Summary and Continuing Care Plan

Client Name:	**DOB:**
Date of Admit:	**Date of Discharge:**

Reason for Discharge:

☐Treatment Completed

☐Lost Contact with client or unknown reasons

☐Client Moved

☐Client declined additional treatment

☐Terminated by provider/agency or Administrative Discharge

☐Client incarcerated

☐Death, Suicide ☐Yes ☐No

☐Client seen for assessment only

☐Transferred to another provider/agency:

Progress/Regress while in treatment:

Referrals made and Continuing Care Plan: