**U.S Probation Office – Western District of North Carolina**

**Mental Health Treatment Discharge Summary**

Client Name: Enter Client Name Discharge Date: Enter Date

Treatment Provider: Enter Program Name

Admission Date: Enter Date

DSM Diagnosis at Discharge: List Diagnoses

Medication(s) Prescribed at Discharge: List Medication(s)

Reason for Termination: (select one)

[ ]  Successful Discharge [ ]  Unsuccessful Discharge [ ]  Interruption of Treatment

Please Explain Discharge Reason

Treatment Outcomes: (Services Provided; description of participation, progress and attendance; treatment plan/goals/objectives achieved or completed. Use additional pages if necessary)

Please Explain Treatment Outcomes

Aftercare-Discharge Plan/Recommendations and Referrals for community-based care:

 Please Explain

Additional Comments: Enter Comments

 Type Clinician Name for Signature Enter Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature Date