Client ID # __________________________ Date of Administration: __________________________

DISCHARGE PLANNING AND DISPOSITION

CLINICIAN-COMPLETED

1. **Date of discharge** [Entered only at discharge]
   ___ ___ (Month) ___ ___ ___ ___ (Year)

2. **What is the primary reason for discharge?** [Entered only at discharge]
   Select primary reason
   - Terminated, refused or declined services
   - Completed program, graduated, or services no longer indicated due to client improvement
   - Client does not display signs and symptoms that lead to the inclusion of a covered diagnosis and/or an established level of impairment
   - Has reached limit for length of allowable stay
   - Pursuing a positive opportunity elsewhere (e.g., school, employment, training)
   - Admitted to state hospital
   - Admitted to a residential program
   - Transferred services to provider outside CSC program (other than state hospital or residential program)
   - Incarcerated
   - Moved out of service area because of reasons other than options noted above
   - Deceased (by suicide)
   - Deceased (by other means)
   - Whereabouts unknown, team unable to contact client
   - Other (Specify: __________________________)

3. **Did team refer for further services?** [Entered only at discharge]
   - Yes
   - No
   - Unknown
4. **Indicate any referrals made for services that were within your agency.**  
   [Entered only at discharge]
   Check all that apply.
   - Medication only
   - Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.
   - Higher level of service
   - Other (Specify: ________________)
   - None
   - Does not apply

5. **Indicate any referrals made for services that were outside your agency.**  
   [Entered only at discharge]
   - Medication only
   - Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.
   - Higher level of service
   - Other (Specify: ________________)
   - None
   - Does not apply