EPINET
Early Psychosis Intervention Network

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