



Discharge / Transfer Form

IDENTIFYING INFORMATION:

CLIENT NAME:		Social Security #:	
Date of Birth:			
Mailing Address:			
Referring Agency:			
DATE of Initiation of Treatment:			
DATE of Conclusion of Treatment:			
Diagnosis at initiation:			
Diagnosis at discharge:			

PRIMARY REASON FOR INITIAL REFERRAL:

Narrative:

REASON FOR DISCHARGE:

Narrative:

ATTEMPTS TO CONTACT CLIENT:

Type of Contact:	✓	BHT comments:	N/A
via Phone			
via Mailed letter			
via Emailed letter			
In-person			
Final letter <i>Inviting client to services</i>			

DISCHARGE PLAN:

Narrative:

Behavioral Health Staff:

Date:

Clinical Advisor:

Date: