

# DREAMS MENTAL HEALTH INC

6600 COW PEN RD STE 300, MIAMI LAKES, FL 33014

## DISCHARGE SUMMARY

<u>Admission Date</u>	<u>Discharge Date</u>	<u>Length of Treatment</u> Days Weeks Months
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### 1. ADMISSION/DISCHARGE STATUS

Summary of Presenting Problems at Time of Admission:
Treatment Summary/Status of Client at time of Discharge:

### 2. PROGRESS (Overall Treatment Progress)

_____ Significant Progress	_____ Minimal Progress	_____ Regression
_____ Moderate Progress	_____ No Progress	_____ Unable to determine

### 3.DISCHARGE (Reason for Discharge/Termination)

<p>_____ • Goals and Objectives on Treatment Plan Completely met.</p> <p>_____ • Goals and Objectives on Treatment Plan Partially met. No other referral necessary.</p> <p>_____ • Client/Legal Guardian Voluntarily Refused Treatment/Service</p> <p>_____ • Non-Compliance with Program Rules and Regulations</p> <p>_____ • Client Moved Out of Area/Unable to Contact</p> <p>_____ • Client Transferred/Referred to Another Service Provider/A Higher Level of Care is Required</p> <p>_____ • Extended Hospitalization: • Psychiatric Hospitalization • Medical Hospitalization</p> <p>_____ • Services not Covered under Client's Current Insurance Plan</p> <p>_____ • Other: _____</p>
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4- **FOLLOW-UP/AFTER CARE**

Follow -up, Aftercare Recommendations and Recovery Plan

5- **SIGNATURES**

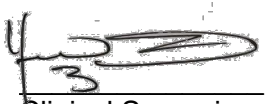
Signature of Person Completing Discharge and Supervisor

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Clinician Print Name

\_\_\_\_\_  
Credentials

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Clinical Supervisor  
Signature

**YEZID ARANGO**  
\_\_\_\_\_  
Clinical Supervisor  
Print Name

**LCSW**  
\_\_\_\_\_  
Credentials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Client Print Name

\_\_\_\_\_  
Date