DREAMS MENTAL HEALTH INC

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

DISCHARGE SUMMARY

Admission Date	**Discharge Date**	***Length of Treatment*** ***Days Weeks Months***

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)

_____• Goals and Objectives on Treatment Plan Completely met.

_____• Goals and Objectives on Treatment Plan Partially met. No other referral necessary.

_____• Client/Legal Guardian Voluntarily Refused Treatment/Service

_____• Non-Compliance with Program Rules and Regulations

_____• Client Moved Out of Area/Unable to Contact

_____• Client Transferred/Referred to Another Service Provider/A Higher Level of Care is. Required

_____ • Extended Hospitalization: • Psychiatric Hospitalization • Medical Hospitalization

_____• Services not Covered under Client's Current Insurance Plan

_____• Other: _____

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
	**YEZID ARANGO**	**LCSW**	
Clinical Supervisor Signature	Clinical Supervisor Print Name	Credentials	Date

Client Signature	Client Print Name	Date