Provider Discharge Summary

Community Counseling Services

Rev 01/17

Case Name: _____

Case Id#: _____

Date of Discharge _____

County of Residence at Discharge _____

13 –Clay 10-Choctaw 44- Lowndes 52-Noxubee 53 – Oktibbeha 78- Webster 80-Winston

REASON FOR DISCHARGE (*Discharge Status*):

- ❑ 1. Evaluation Only
- ❑ 2. Completion of Treatment goals.
- ❑ 3. Provider Terminated Treatment
- ❑ 4. Individual Referred Elsewhere.
- ❑ 5. Individual requested discharge
- ❑ 6. Individual Moved from service area
- ❑ 7. Individual Deceased
- ❑ 8. No Contact in a 12 months

❑ **Goals Met** ❑ **Goals Not Met**

DISCHARGE INSTRUCTIONS GIVEN TO: ❑ **THE INDIVIDUAL** ❑ **LEGAL REPRESENTATIVE**

DISCHARGE INSTRUCTIONS/ADDITIONAL INFORMATION:

REFERRED TO: _____

01- DMH Psychiatric Hospital	09- Self	17- Voc Rehab/Job Placement
02- Other MS CMHC	10- Family/Friend	18- Nursing Home
03- DMH IDD Facility	11- School/Education	19- Boarding Home
04- Private Psychiatric Hospital	12- Employer/EAP	20- Group Home (non-DMH)
05- Other MH Provider	13- Police/Sheriff	21- Other Social Service Agency
06- Other IDD Provider	14- Courts/Corrections	97- Other
07- Other A&D Provider	15- Probation Parole	98- Unknown
08- Gen/Hospital/Other Health	16- Self Help Program	99- None

Referral Organization: _____ ***if applicable (see Face-sheet for codes)***

A&D Discharge Form *Required if individual has an A&D dx or disability treatment category.*

_____

Individual/Legal Representative **Date**
(if able to obtain signature)

_____ _____

Staff /Credentials **Date** **Staff Supervisor** **Date**