FORENSIC DISCHARGE SUMMARY
_____ MENTAL HEALTH INSTITUTE

SERVICE RECIPIENT INFORMATION

Service Recipient's Name _____ SSN _____- _____- _____ Chart # _____

Date of Admission _____ Discharge Date _____ Date of Birth _____

Legal Status at Admission : ☐ -301(a) ☐ - 301(b) ☐ -303(c)

Legal Status at Discharge : ☐ -301(a) ☐ - 301(b) ☐ -303(c)

DISCHARGE LOCATION INFORMATION

Discharge Location: To jail Yes ☐ No ☐ Living arrangements: Home ☐ Group home ☐ Relative ☐ Other ☐

If other specify _____

Address: _____

AFTERCARE INFORMATION

Diagnosis:

Code	Primary Diagnosis	Category/Axis
Code	Diagnosis	Category/Axis
Code	Diagnosis	Category/Axis
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Outpatient Forensic Coordinator/Agency_____ Phone:_____

Med. Monitoring ☐ Competency Training ☐ Competency Assessment ☐

MOT required? Yes ☐ No ☐

CMHC responsible _____ Date initiated _____ Attach copy of MOT Plan _____

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Outpatient referral for clinical services: Yes ☐ No ☐ Agency_____ Type of Services Recommended: CM ☐ CTT ☐ Med. monitoring ☐ Supervised Residential ☐ RTC/RTF ☐ A&D ☐

Explain if no OP referral:

_____

DISCHARGE MEDICATIONS: Physician's Discharge Order Attached

SPECIFIC INSTRUCTIONS TO THE COMMUNITY MENTAL HEALTH AGENCY: for follow-up /after care services:

_____
_____
_____
_____

Forensic Issues (check one)			**Clinical Issues** (check one)
☐	**Level 1**	- within 2 weeks from RMHI/FSP Discharge Date	☐ **Level 1**
☐	**Level 2**	- within 1 month from RMHI/FSP Discharge Date	☐ **Level 2**
☐	**Level 3**	- within 2-3 months from RMHI/FSP Discharge Date	☐ **Level 3**
☐	**Level 4**	- No follow-up recommended	☐ **Level 4**

_____ _____
Facility Representative Signature and Credentials Date/Time