**San Diego County Mental Health Services**

**CSU Episode Summary**

**\*Client Name:**      **\*Case #:**

**\*Discharge Date:**       **\*Program Name:**

\*Date of admission:

\*Mode of arrival: Choose an item.

If Law Enforcement was selected, please specify: Choose an item.

\*Insurance?  No  Yes  Unknown

(If Yes, check all that apply)

Medi-Cal

Medicare

Private Insurance/ VA/ Tricare

\*Legal Status upon Admission:

Voluntary  72 Hour Hold for Adults  72 Hour Hold of Minors

First 14 Day Hold  Second 14 Day Hold  Additional 30 Day Hold

Additional 180 Day Hold  Other Involuntary Civil Status

Charges/Convictions Pending  Incompetent to Stand Trial

Not Guilty By Reason-Insanity  Sexual Psychopathy

Transfer Correction Facility  Other Involuntary Criminal

Petition for Evaluation  Conservatorship

Did client’s legal status change post-admission:  Yes  No; If yes, indicate change:

**\*REASON FOR ADMISSION**  *(Describe events in sequence leading to admission to your program. Describe primary complaint upon admission. Summary of client’s request for services including client’s most recent baseline. Include measurable and observable impairment behaviors. Mental Status at time of admission. Previous treatment, if known.)*

**COURSE OF TREATMENT**

\*Discharge Reason: Choose an item.

If Other, explain:

\*Discharge Destination: Choose an item.

\*If Other, explain:

\*Upon Discharge, is client Homeless?  Yes  No

\*Upon discharge, what was client’s mode of transportation: Choose an item.

If Other, explain:

Summary of Services:  *Response to treatment/progress, and reason for discharge, including healing and health services. Include any cultural considerations during the course of treatment.*

Care Coordination with MH Provider  Care Coordination with PCP

Psychiatric Evaluation  Risk Assessment  Medications Administered

Family Counseling  Individual Counseling  Group Therapy

Psychoeducation on Coping Skills  Safety Planning

Case Management Services  Recreational Activities  Placement Assistance

Socialization with Peers

For any box checked above, please describe client’s progress/level of participation:

Aftercare Plan:  *Information provided to client/family at discharge and recommendations, appointments, discharge location, substance use treatment recommendations.*

**MEDICAL HISTORY:**

Psychiatric Medications at Discharge (if possible, include dosage and frequency of medication; indicate if medications were given in-hand or prescription):

Allergies and adverse medication reactions:  No  Unknown/Not Reported  Yes

If yes, specify:

Other prescription medications:  None  Yes  Unknown

If yes, specify:

**HISTORY OF VIOLENCE**:

History of domestic violence:  None reported  Yes

History of significant property destruction:  None reported  Yes

History of violence:  None reported  Yes

*Specify type, intensity, and if past or current*.

History of abuse:  None reported  Yes

*Specify type, intensity, and if past or current.*

Abuse reported:  N/A  No  Yes

If Yes, specify:

\*Experience of traumatic event[s]:

No  Yes  Unknown/not reported

If Yes: *Describe traumatic experience and summarize impact**.*

**REFERRAL(S)**: *Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.*

\*Referred to: Choose an item.

If Other, Specify:

Appointment Date:       Time:

Client or caregiver declined referral(s)

**Signature of Clinician Requiring Co-signature**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name:       CCBH ID number:

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary**