

**CENTRAL STATE HOSPITAL
RELEASE NOTIFICATION**

Admitted: ____/____/____ Agency Referred To: _____

Discharge: ____/____/____ Attention: _____ () _____

Phone

Type of Release:

Legal Status:

Direct Discharge 9
AMA 9
LWC 9
Other 9

Admission:

Voluntary 9
Involuntary 9
Court Order 9

Release:

Voluntary 9
Involuntary 9
Court Order 9

Condition Upon Release: _____ Outpt. Commitment Status: _____

Expiration Date: ____/____/____

Released in the Company of: _____

Final

Diagnosis:

Axis I: _____

 Axis II: _____

 Axis III: _____

 Axis IV: _____
 Axis V: _____

Medication Prescribed and/or Dispensed at Time of Release:

| Medication | Dosage | Prescribed | | | Dispensed (By CSH) | | |
|------------|--------|------------|----|--------|--------------------|----|--------|
| | | Yes | No | Supply | Yes | No | Supply |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Stamp Plate

TREATMENT CONSIDERATIONS

(A) Possible Management Problems: *Additional Comments/Information*

| | | |
|--------------------------|---|-------|
| Alcohol Abuse | 9 | _____ |
| Combativeness | 9 | _____ |
| Developmental Disability | 9 | _____ |
| Drug Abuse | 9 | _____ |
| Seizures | 9 | _____ |
| Senility | 9 | _____ |
| Suicidal | 9 | _____ |
| Withdrawal | 9 | _____ |
| Overactive | 9 | _____ |
| Pain | 9 | _____ |
| Infection/+PPD | 9 | _____ |
| Other | 9 | _____ |

(B) Community/Residential Arrangement:

Home 9 Other 9

_____ () _____

Address & Phone Number

(C) Treatment Approaches To Consider:

| | | | | | |
|-----------------|---|---------------------------|---|-------|---|
| Counseling | 9 | Medications | 9 | Other | 9 |
| Family Casework | 9 | Vocational Rehabilitation | 9 | | |

(D) Appointment: _____

Place

_____ Date _____ Time _____ AM/PM

(E) Additional Comments: _____

| | | |
|--------------------|-------|-------------------|
| _____ | _____ | (478) 445-_____ |
| Physician | Date | Phone |
| _____ | _____ | (478) 445-_____ |
| CSH Contact Person | Date | Phone |

Copy Sent to: Patient 9 Representative 9 Cashier's Office 9 Other 9 _____

Copies Sent to _____ : Admission Summary 9 Final Summary 9
Immunization/Infectious Disease Screening Record 9 Release Notification 9 Serology 9 Urine
Drug Screen 9 Other 9 _____