



Department of Behavioral Health &
Developmental Disabilities
Central State Hospital

DBHDD

Aftercare Follow-up

Patient Information

Name:

Unit:

Race:

County of Residence:

Date of Birth:

Admit Date:

Avatar#:

Current Episode:

DISCHARGE INFORMATION

Discharge Date:

Core Provider:

Discharge Principal Diagnosis:

Discharge Secondary Diagnosis:

Referred To Appt Date:

Referred To:

Discharge Remarks:

Discharge Physician:

Client's Home Phone #:

SERVICE PROVIDER

TYPE OF FOLLOW-UP CONTACT:

Individual Contact Post Discharge:

Source of Information:

Contact Date/Time: @

Was Contact Successful?

Social Service staff making contact:

Aftercare narrative:

Community Agency Contact Post Discharge:

Initial aftercare appointment made at time of discharge?

Date/time of next appointment: @

If no initial appointment made, was community liaison/service provider agency notified?

Treatment Adherence:

If non-adherent with treatment, reasons cited:

Date and time of initial appointment with CSB or other mental health provider: @

Did the individual arrive for the appointment?

Contact Narrative:

Received Outpatient Provider Services:

Description:

Received Residential Services:

Description:

Received Educational/Vocational Services:

Description:

Received Legal services:

Description:

Received Medical/Dental Services:

Description:



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Current Episode:

Received Other Community Services:

Description:

Received Specialized Treatment Needs/Services:

Description:

MEDICATION AFTER DISCHARGE

Were medications provided at discharge?

Medication adherence after discharge?

If non-adherence with medications, reasons cited:

Were medications refilled at community provider location?

Were medications refilled at local pharmacy?

Were medications changed by the community provider?

What were the medications at discharge?

If medications change, please indicate the name and dosage:

SIGNATURES

Social Service Signature:

Signature Date: