



Department of Behavioral Health &
Developmental Disabilities
Central State Hospital

DBHDD

Social Work Discharge Summary

Patient Information	
Name:	
Unit:	
Race:	
County of Residence:	
Date of Birth:	Admit Date:
Avatar#:	Current Episode:
SSN:	

DISCHARGE DATA

Discharge/Release Date:

Referred To:

Outpatient Commitment Status:

Condition of Bond:

Conditional Release Plan:

Parole:

Probation:

Other Legal Services:

Legal Services Comments:

Legal Status Upon Discharge/Release:

Reason for Discharge:

Expiration Date:

Expiration Date:

Expiration Date:

Expiration Date:

Expiration Date:

Expiration Date:

FINANCIAL DATA

Current Financial Resources and Amount of Income:

SSI:

SSDI:

Veteran/Military:

Welfare:

Child Support:

Insurance:

Medicaid Number:

Medicare Number:

Other Insurance Name:

Other Insurance Number:

RESIDENTIAL ARRANGEMENTS

Residential Care Giver Name:

Residential Address:

Residential Phone:

Payee:

Residential Arrangements made by:

Residential Type of Community Residence:

Transportation Upon Discharge:

OTHER COMMUNITY SERVICES

Other Community Services:

Other Community Comments:



Department of Behavioral Health &
Developmental Disabilities
Central State Hospital

DBHDD

Social Work Discharge Summary

Patient Information	
Name:	
Unit:	
Race:	
County of Residence:	
Date of Birth:	Admit Date:
Avatar#:	Current Episode:
SSN:	

AGENCIES AND SERVICES REFERRED

Agency Referred To:

Address:

Agency Contact:

Phone Number:

Date of Appointment:

Fax Number:

Time of Appointment:

SERVICES RECOMMENDED

Recommended Outpatient Provider Services:

Description:

Recommended Residential Services:

Description:

Recommended Educational/Vocational Services:

Description:

Recommended Medical Dental:

Description:

Recommended Specialized Treatment Needs/Services:

Description:

AGENCIES AND SERVICES REFERRED

Agency Referred To:

Address:

Agency Contact:

Phone Number:

Date of Appointment:

Fax Number:

Time of Appointment:

SERVICES RECOMMENDED

Recommended Outpatient Provider Services:

Recommended Residential Services:

Recommended Educational/Vocational Services:

Recommended Medical Dental:



Department of Behavioral Health &
Developmental Disabilities
Central State Hospital

DBHDD

Social Work Discharge Summary

Patient Information

Name:

Unit:

Race:

County of Residence:

Date of Birth:

Admit Date:

Avatar#:

Current Episode:

SSN:

AGENCIES AND SERVICES REFERRED

Agency Referred To:

Address:

Agency Contact:

Phone Number:

Fax Number:

Date of Appointment:

Time of Appointment:

SERVICES RECOMMENDED

Recommended Outpatient Provider Services:

Recommended Residential Services:

Recommended Educational/Vocational Services:

Recommended Medical Dental:

RECOMMENDED SPECIALIZED TREATMENT NEEDS/SERVICES:

Social Service Signature:

Signature Date:

Discharged Individual Signature:

Signature Date:

Individual Released/Discharged to:

Signature Date: