

North Shore Mental Health  
 Adult Mental Health Division  
 DISCHARGE & AFTERCARE PLAN

<u>Name of Client:</u>		<u>CR#:</u>
<u>Client's Birthdate:</u>	<u>Admission Date:</u>	
<u>Level(s) of Care:</u>	<u>Transfer/Discharge Date:</u>	
<u>Reason for Referral:</u>		
<u>Client Strengths and Abilities:</u>		
<u>Initial Diagnosis (include all 5 axis):</u> I II III IV V		
<u>Initial Treatment Goals:</u>		
<u>Course of Treatment (include services provided and client response to services):</u>		
<u>Treatment Goals Achieved:</u>	<u>Treatment Goals Unmet:</u>	
<u>Transfer/Discharge Diagnosis:</u> I II III IV V		
<u>Reason for Transfer/Discharge:</u>		
<u>Referrals Made:</u>		
<u>Recommendation(s):</u>		
<b>Print Name and Title:</b> _____		<b>Date</b>
<b>Signature:</b> _____		