

**North Shore Mental Health
Adult Mental Health Division
TRANSFER/DISCHARGE SUMMARY**

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