

Health Care for the Homeless, Inc.
ADDICTION DISCHARGE SUMMARY

ADMISSION DATE:	DISCHARGE DATE:	S.S.#:
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DATE OF BIRTH:	GENDER:	RACE:	MARITAL STATUS:
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REASON FOR DISCHARGE:

<input type="checkbox"/> Completed Treatment - No Drug Use	<input type="checkbox"/> Transferred to Non-SAMIS Clinic within Program	<input type="checkbox"/> Left Before Completing Program
<input type="checkbox"/> Completed Treatment -Some Drug Use	<input type="checkbox"/> Referred to Outside Program	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Transferred to Another SAMIS Clinic within Program	<input type="checkbox"/> Non-Compliance with Program Rules	<input type="checkbox"/> Deceased

ENVIRONMENT AT DISCHARGE:

<input type="checkbox"/> Outpatient	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Residential (28-Day)	<input type="checkbox"/> Prison	<input type="checkbox"/> Methadone	<input type="checkbox"/> Intensive Outpatient
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EMPLOYMENT STATUS:

HIGHEST GRADE COMPLETED:	COMPLETED EDUCATIONAL/VOCATIONAL PROGRAM? <input type="checkbox"/> Yes <input type="checkbox"/> No	NUMBER OF TIMES ARRESTED DURING TREATMENT::
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TYPE OF INSURANCE:

TREATMENT PLAN OBJECTIVES ACHIEVED:

	YES	NO	NA		YES	NO	NA		YES	NO	NA		YES	NO	NA
Employment				Medical				Drug Use				Legal			
Psychosocial				Education				Skill Development							

PROGRAM VIOLATIONS:

TREATMENT RECOMMENDATIONS:

PROGNOSIS:

COUNSELOR SIGNATURE:	DATE:
ADDICTION COORDINATOR:	DATE:

CLIENT LAST NAME:	FIRST:	HCH#:
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