ALBERTA PROFESSIONAL SERVICES, INC.

DISCHARGE SUMMARY

Client Name:_____

Record No: _____Medicaid #: _____

Date of Admission: _____ Date of Discharge: _____

Date of Notice: _____ Home MCO:_____

Person Initiating Transition:_____

Reason for Transition:_____

_____

_____

Presenting Problem: _____

_____

_____

Services Provided: _____

Response to Treatment: _____

_____

_____

Client's Strengths:_____

_____

Client's Needs: _____

_____

Client's Abilities: _____

_____

_____

Client Name:_____

Record No: _____Medicaid #: _____

Preferences: _____

_____

_____

Discharge Diagnoses:_____

_____

_____

_____

_____

Discharge Medications: _____

_____

_____

_____

_____

Discharge Plan and Recommendations: _____

_____

_____

_____

_____

_____

_____

ALBERTA PROFESSIONAL SERVICES, INC.

Client Name:_____

Record No: _____Medicaid #: _____

Referral for continuing services:
(include contact name, telephone number, locations, hours, and days of service)

_____

_____

_____

_____

_____

_____
Signature of Client: Date:

_____
Signature of Guardian/Parent: Date:

_____
Signature, Credentials & Title of Agency Representative: Date:

_____
Signature of Team Member: Date:

_____
Signature of Team Member: Date:

This forms meets these standards
Authority: 122C-57, 61, 63, 205.1, 212, 224.7, 242; 10ANCAC 27G. 1708, .1806, 10A NCAC 27d.0102; CARF 2013 BH 2.D.1-8