

FORENSIC DISCHARGE SUMMARY

MENTAL HEALTH INSTITUTE

SERVICE RECIPIENT INFORMATION

Service Recipient's Name _____ SSN _____ - _____ - _____
Date of Admission _____ Discharge Date _____ Date of Birth _____
Legal Status at Admission : -301(a) - 301(b) -303(c)
Legal Status at Discharge : -301(a) - 301(b) -303(c)

DISCHARGE LOCATION INFORMATION

Discharge Location: To jail Yes No Living arrangements: Home Group home Relative Other
If other specify _____
Address: _____

AFTERCARE INFORMATION

Diagnosis: _____

Outpatient Forensic Coordinator/Agency _____ Phone: _____
Med. Monitoring Competency Training Competency Monitoring
MOT required? Yes No
CMHC responsible _____ Date initiated _____ Attach copy of MOT Plan _____
Outpatient referral for clinical services: Yes No Agency _____ Type of Services
Recommended: CM CTT Med. monitoring Supervised Residential RTC/RTF A&D
Explain if no OP referral: _____

DISCHARGE MEDICATIONS: Physician's Discharge Order Attached

SPECIFIC INSTRUCTIONS TO THE COMMUNITY MENTAL HEALTH AGENCY: for follow-up /after care services:

Forensic Issues (check one)

- Level 1** - within 2 weeks from RMHI/FSP Discharge Date
- Level 2** - within 1 month from RMHI/FSP Discharge Date
- Level 3** - within 2-3 months from RMHI/FSP Discharge Date
- Level 4** - No follow-up recommended

Clinical Issues (check one)

- Level 1**
- Level 2**
- Level 3**
- Level 4**

Facility Representative Signature and Credentials

Date

PATIENT IDENTIFICATION (Label)



Dept. of Mental Health and Substance Abuse Services

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