Discharge Summary for Mental Health Treatment Programs

Family Name:	Given Name(s):	Date of Birth: (yyyy-mm-dd)
VAC File No.:	Admission Date: (yyyy-mm-dd)	Discharge Date: (yyyy-mm-dd)
VAC Area Counsellor (Case Manager):		Tel.:
Family Physician:		

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1. Referral Source: ☐ Psychiatrist ☐ Psychologist ☐ Social Worker
   ☐ Family Physician ☐ Other:_____

   What was the expected benefit of treatment:

2. Presenting problem (include diagnostic information, if available):

3. Treatment objectives:

4. Interventions that were utilized:

- ☐ Group sessions
- ☐ Individual sessions
- ☐ Medical/Rx
- ☐ Other: _____
- ☐ Family consultation/education
- ☐ Consultation with external professionals
- ☐ Peer involvement

5. Has there been a change in diagnosis? Please explain:

6. Have there been changes in prescribed medications upon discharge? Please explain:

Note: If changes are recommended, please provide a letter of explanation to client for use regarding drug reimbursement.

7. Program(s) attended:

8. Did client tolerate treatment and environment well? Please explain:

9. Did treatment help the client meet stated treatment objectives? Please explain:

10. Is the client's discharge supported by the treatment team? Please explain:

11. Family consultation

Give a brief description of interaction with family and any recommendations for continuing family therapy (if applicable):

12. Are there specific vocational rehabilitation considerations? Please explain:

13. Was there a pre-discharge conversation with the Area Counsellor? Please explain:

14. Aftercare recommendations:

- ☐ Referral to Operational Stress Injury Social Support (OSISS) peer support or family support co-ordinator
- ☐ Individual therapy sessions with Psychologist or Social Worker
- ☐ Family intervention
- ☐ Pain management
- ☐ Psychoeducational group
- ☐ Attend 12 step program
- ☐ Continuation of specific programs used in inpatient stay (e.g. Najavits, Seeking Safety, Cognitive Behaviour Therapy (CBT), Anger Management, Stress Management and Relaxation)
- ☐ Structured: leisure activities, nutrition, exercise, physiotherapy, walking
- ☐ Specialized case management (Clinical Care Manager)
- ☐ Additional inpatient programming

Comments:

15. Other issues that could not be addressed during treatment:

16. Is the client in agreement with the above summary and recommendations? Yes ◯ No ◯
Please explain:

17. Names of professionals, roles and scheduled meetings to occur post-discharge:

Client's Signature:	Date: (yyyy-mm-dd)
Treating Professional or Physician's signature:	Date: (yyyy-mm-dd)