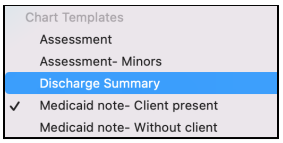
Options for Discharge Summary

As a reminder, information regarding standards and timelines has been copied from the Therapist Guide and included at the end of this document.

A) If you know it will be your client's final session, you can switch the note template to the discharge summary and complete it as the progress note (see screenshots). This option includes an extra section for brief information about session content. For example, "Client attended termination session. Client and clinician processed feelings about ending therapy and reviewed significant experiences in their work together… etc."



B) Alternatively, you can complete the summary in a quick note by copying and pasting the template below. You'll notice some answers are included for you (in all versions) due to the nature of the questions**.**

C) You can complete the fillable template available on the shared drive and upload it to the chart.

DISCHARGE SUMMARY TEMPLATE

Date of discharge:

Reason for admission:

Reason for discharge:

Diagnosis:

Primary/significant issues identified during treatment:

Summary of services, progress in treatment, and outstanding concerns:

Coordination of care with other service providers:

Advanced directives developed or initiated during course of services:
Deferred.

Summary of medications prescribed during treatment and individual's response to medications: *This information is outside the scope of services provided by the therapist.*

Medications recommended and prescribed at discharge:
No medications have been prescribed or recommended to client by therapist. Client is recommended to refer all questions related to medication to the prescriber, if currently applicable.

Summary of legal status during course of services and at time of discharge (for example, client on probation):

Referrals and recommendations for follow-up care:

Response of client and/or family to discharge:

Options for Discharge Summary

Discharge Summary Standards

Routine Discharges

Ensure discharge summaries are completed for all clients. Discharge summaries should be completed within 30 days of a client's discharge from services, and sooner when possible. The discharge summary template in TA should be used for this purpose. Discharge summaries do not need to be completed for clients who were scheduled to see you but were never seen.

High Acuity Clients

High acuity clients should have a discharge summary completed as soon as possible due to the increased need to indicate the client is no longer under your care.

60 Days Inactive

Clients who have been inactive for 60 days for any reason should be contacted and, depending on the outcome, considered for discharge.

Clients who express the intention to "take a break" from services, or those who are prone to participating intermittently in therapy should have a discussion with the therapist about the point at which the therapist will follow up with the client. **After 60 days**, if there is no contact from the client, the therapist should attempt to clarify if the client would like to return for services. If the client would like to continue the break, has moved on to another provider, or cannot be reached, this should be noted in the chart and the client should be discharged. The client (if reachable) may be informed that they are welcome to return for services if they desire, they'll simply have a new intake appointment.

This is not about shutting out the client, but rather about liability, as until they are discharged they remain under your care and you (as well as FPCC) could be held liable for some aspects of their well being.