MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS DISCHARGE SUMMARY

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Primary Program:

Address

Case Holder:

Disability Designation:

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1. **Closing Report**
2. Send Copy to
3. Signatures

1. Discharge Summary: Closing Report

Date Opened **Date Last Seen** **Date Closed**

Use Current Date Use Current Date

Last Service Date (auto-calculated based on SALs and Claims)

Final Diagnosis

		ICD-9	DSM-IV	Description	Status Date	Status
AXIS I	Pri					
	Sec					

Substance Abuse Diagnoses

	ICD-9	DSM-IV	Description	Status Date	Status

No diagnoses exist

		ICD-9	DSM-IV	Description	Status Date	Status
AXIS II	Pri					
AXIS III	Pri					

AXIS IV

- ☐ Economic problems
- ☐ Problem accessing healthcare
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Problem with primary support group
- ☐ Problem related to social environment
- ☐ Problem related to interaction with legal system
- ☐ Other psychosocial and environmental problems
- ☐ Behavioral / Personality issues

AXIS V

Current GAF **Date**

Use Current Date

Show Functional Assessment Measure History

Diagnostic Formulation

characters left: 4096

Co-Occurring Consumer Quadrant

Co-Occurring Consumer Quadrant Comments

Additional Information / Help

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Diagnosis Made By (Name/Credentials) **Diagnosis Effective Date**

Use Current Date

History of Diagnosis lookup **Last Updated**

Disability Designation

Developmental Disability

○ Yes ◉ No

Mental Illness

SUD

◉ No SUD

○ Not Evaluated for SUD

1 or more SUD Dx Codes active or in partial remission (use within past year)

○ Yes ◉ No

○
○ 1 or more SUD Dx Codes with all SUD Dx codes in full remission (no use for 1 year)
○ Results from screening suggest SUD

Individual received an assessment only, and was found to meet none of the disabilities listed above

○ Yes ◉ No

Describe Services Provided

Include Primary and Ancillary Services

characters left: 16384

Notes

Please describe reason for discharge, condition/status of consumer at last contact, progress (or lack of progress) achieved toward established goals.

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Further Service Recommendations or Referrals

include date of follow-up and with whom, if appropriate

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Reason for Discharge

According to Plan

○ The outcomes and dreams in the Person Centered Plan have been substantially met and the consumer/family no longer desires or requires additional services
○ Referred to Primary Care Physician and/or other community agencies and natural supports for services
○ Consumer/Family relocated out of service area and appropriate referrals and linkages have been made
○ Consumer has responded to the services and support offered in current program, now meets criteria for less restrictive service
○ Consumer's needs are not adequately met through current program, referred to higher intensity of service
○ Consumer continues to need services at the current level of care, but at a different provider (i.e., transfer)

Not according to Plan

○ Consumer/family withdraws their consent for services and all appropriate attempts to offer ongoing services have been made
○ Consumer/family misses scheduled appointments, does not respond to follow up contact by staff, can't be located or leaves AMA
○ Consumer/Family relocates out of service area without appropriate referrals in place

Other

○ Consumer request

- Consumer incarcerated (prison/long-term jail sentence)
- Consumer deceased Date of Death (if known):
  - Cause of Death:
  - If Natural Causes, Select a Sub-Category:
- Consumer does not meet criteria for services
- Transfer to State Institution, nursing home or medical unit of hospital
- No show / no contact / no service provided
- Other:

Notes

characters left: 1024

Closing Summary

characters left: 16384

Consumer Satisfaction

Satisfaction with Services Rendered

- Satisfied
- Not Satisfied (explain)
- Not Discussed (explain)

Comments (use direct quotes from consumer, when possible)

characters left: 1024

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Once this document has been signed, it will be copied and sent to all parties listed below. For all documents that are to be sent outside of your agency, please be sure you have a valid Authorization for Release of Information before adding this copy request.
- To notify staff of document completion, click on **Send to Staff**.
- To send a copy of this document to a location outside of your agency, click on **Send External Copy**.

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2. Closing Report: Send Copy to

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Location: lookup clear **Contact Name:** **Purpose:**	

Send to Staff Send External Copy

Record Added **Record Changed**

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3. Closing Report: Signatures

Please remember to early terminate authorizations as of the discharge date.

Electronic Signatures

Instructions

When the form/document is completed, type in your password and click 'Sign and Save'. By entering your password you are electronically signing this form/document. Your signature represents your acceptance and approval of the records. Once signed, any future changes must be made via the 'Change Signed Document' option.

Staff Signature Required By lookup

Enter your password to sign

Sign and Save

Digital Signature To Be Obtained By lookup clear **To Be Signed By**

Digital Signature To Be Obtained By lookup clear **To Be Signed By**

Supervisor Signature lookup clear

Physician Signature lookup clear

Physician signature required for Blue Cross/Blue Shield and also may be required for other insurance policies

Record Added **Record Changed**

Save CANCEL

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