Discharge Management Plan Template

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Admit date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Discharge date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Discharge Level of Care:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My diagnoses during treatment at [facility name] were: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am being discharged because:**

* I have achieved my goals of:
* I am still working on goals of:
* I reported I was leaving against medical advice because:
* My treatment provider offered/encouraged the following when I reported that I wanted to leave against medical advice:
* I have been administratively discharged.

# **My Medications after discharge:**

**New Medications (take at home):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency****/Schedule** | **Reason for Medication/Special Instructions** | **Rx given or name of pharmacy called to:**  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Changed Medications (take at home-but may have different dose or frequency/schedule):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency****/Schedule** | **Reason for Medication/Special Instructions** | **Rx given or name of pharmacy called to:**  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Stopped Medications (DO NOT TAKE at home):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency****/Schedule** | **Reason for Medication/Special Instructions** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Community Supports for me to use after discharge:**

1. AA/NA group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Recovery Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Housing Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Volunteer Opportunities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Education Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. My recovery supports and their contact information (such as sponsors, family, friends):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Support groups/treatment providers related to specific trauma concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Other supports/referrals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My treatment provider recommended the following services for after discharge:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **My Aftercare Appointments:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Appointment 1** | **Appointment 2** | **Appointment 3** | **Appointment 4** | **Appointment 5** |
| **Type of appointment****(MAT, trauma, PCP, MH, SA)** |  |  |  |  |  |
| **Provider/Clinic Name** |  |  |  |  |  |
| **Address** |  |  |  |  |  |
| **Phone #** |  |  |  |  |  |
| **Date of Appointment** |  |  |  |  |  |
| **Time** |  |  |  |  |  |
| **Transportation to appointment via:**  |  |  |  |  |  |

**My Barriers to maintaining recovery/attending aftercare:**

|  |  |
| --- | --- |
| **Barriers** | **Resolutions** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Relapse Prevention Planning**

**I have developed a separate Relapse Prevention Plan that includes stressors/triggers, early warning signs, steps to take to prevent a relapse, contact numbers, and other supports I can use to maintain my recovery. I have a copy of this document to take with me upon discharge.**

* **Yes, I have a relapse prevention plan**
* **No, I do not have a plan. I declined to create a plan.**

By signing this document, I am acknowledging that I have completed this discharge management plan, I understand the plan, and have reviewed it with a staff member. I have received a copy of this plan.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

By signing this document, I acknowledge that the discharge management plan was completed and reviewed with the patient and that the patient has received a copy of this plan.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Member Date

*This is a template, and should not be considered to be an exhaustive listing of all that may be needed for a discharge management plan. All providers are responsible for ensuring each PerformCare Member is provided a thorough and individualized discharge management plan.*