

# Discharge Management Plan Template

Name: \_\_\_\_\_

Admit date: \_\_\_\_\_

Address: \_\_\_\_\_

Discharge date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Discharge Level of Care: \_\_\_\_\_

My diagnoses during treatment at [facility name] were:

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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 NOI 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.

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Patient

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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.

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Staff Member

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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.*