EPINET
Early Psychosis Intervention Network

Client ID # _____   Date of Administration: _____

DISCHARGE PLANNING AND DISPOSITION

CLINICIAN-COMPLETED

1.   **Date of discharge** *[Entered only at discharge]*
     ___ ___ (Month)   ___ ___ ___ ___ (Year)

2.   **What is the primary reason for discharge?** *[Entered only at discharge]*
     Select *primary* reason
     ○   Terminated, refused or declined services
     ○   Completed program, graduated, or services no longer indicated due to client improvement
     ○   Client does not display signs and symptoms that lead to the inclusion of a covered diagnosis and/or an established level of impairment
     ○   Has reached limit for length of allowable stay
     ○   Pursuing a positive opportunity elsewhere (e.g., school, employment, training)
     ○   Admitted to state hospital
     ○   Admitted to a residential program
     ○   Transferred services to provider outside CSC program (other than state hospital or residential program)
     ○   Incarcerated
     ○   Moved out of service area because of reasons other than options noted above
     ○   Deceased (by suicide)
     ○   Deceased (by other means)
     ○   Whereabouts unknown, team unable to contact client
     ○   Other (Specify: _____)

3.   **Did team refer for further services?** *[Entered only at discharge]*
     ○   Yes
     ○   No
     ○   Unknown

4. **Indicate any referrals made for services that were *within* your agency. *[Entered only at discharge]***

Check all that apply.

☐ Medication only

☐ Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.

☐ Higher level of service

☐ Other (Specify: _____)

☐ None

☐ Does not apply

5. **Indicate any referrals made for services that were *outside* your agency. *[Entered only at discharge]***

☐ Medication only

☐ Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.

☐ Higher level of service

☐ Other (Specify: _____)

☐ None

☐ Does not apply