FORM # 693 Discharge

Clark Quality Care

To be completed within 10 days of discharge

NAME:	**SS#**
MEDICAID#:	**DOB:**
ADDRESS:	**REPRESENTATIVE NAME / NUMBER**
DATE OF ADMISSION:	**DATE OF DISCHARGE:**
CSB:	**SUPPORT COORDINATOR:**

REASON FOR ADMISSION

LEGAL STATUS: (if incompetent, give guardian's name and address, and date of court order)

NAME AND ADDRESS OF NEAREST RELATIVE:

FINANCIAL RESOURCES:

DISCHARGE MEDICATIONS: **DOSAGE AND TIME:** **PURPOSE:**

STATUS, LOCATION, AND ARRANGEMENT FOR FUTURE SERVICES:

REASON FOR DISCHARGE:

INDIVIDUAL'S LEVEL OF FUNCTIONING / FUNCTIONAL LIMITATIONS:

RECOMMENDATIONS FOR TREATMENT: (procedures, activities, referrals)

PROGRESS IN ACHIEVING GOAL AND OBJECTIVES:

CONTINUED CARE RECOMMENDATIONS:

FOLLOW UP SERVICES:

DEGREE OF INDIVIDUAL / AR PARTICIPATION IN THE PLAN PROCESS:

DEGREE OF PLACING AGENCY'S PARTICIPATION IN THE PLANNING PROCESS:

_____ **Date:** _____
Signature / Title of Person Completing Summary

_____ **Date:** _____
Signature of Individual

_____ **Date:** _____
Signature of Guardian / AR

_____ **Date:** _____
Signature of Support Coordinator