

EASA PROGRAM – DISCHARGE FORM

(Use only if client discharged out of the program after Intake Visit was completed)

IDENTIFIERS – Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values

Full Name _____ DOB _____

FORM DETAILS

Year Quarter ☐ 1 Jan-Mar ☐ 2 Apr-Jun ☐ 3 Jul-Sep ☐ 4 Oct-Dec

HEALTH

ICD-10 Codes (Only complete codes if it is the participants' FIRST quarter of treatment or if the participant has been discharged, otherwise leave blank)

_____ ☐ SIPS (Psychosis Risk Syndrome)

Notes _____

DISCHARGE TRANSFER

Discharge Date _____ Last Date Client Received Services _____

Did Client have a Transition Plan when they were Discharged?

- ☐ Yes
☐ No

Primary Reason for Discharge from EASA

- ☐ Completed Program – Achieved all or most of program goals
☐ Completed Program – Achieved some program goals
☐ Completed Program – Achieved few or none of program goals
☐ Moved, specify where* _____
☐ Discharged/ Lost Contact
☐ Chose other services, specify _____
☐ Not appropriate for the program
☐ Incarceration
☐ Suicide
☐ Death (not suicide)
☐ Other, specify _____
☐ Unknown

***Referred to a Different EASA County/ Agency?**

- ☐ Yes
☐ No
☐ Unknown

***Agency Name Client Referred To**

} Complete
questions to
right
