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*_____ } Complete questions to right
- ○ 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**

_____