**BEHAVIORAL HEALTH DISCHARGE**

*(Send when BH treatment services are ending)*

**TO: Primary Care Provider (PCP)** Address:

Phone: *Office:* *Cell:*

Email: Fax:

**FROM: Behavioral Health Provider**: Address:

Phone: *Office:* *Cell:*

Email: Fax:

**RE:** Patient Name: Date of Birth: \_

☐ Date patient last seen:

**Discharge Diagnoses:**

1.

2.

3.

**Reason for discharge:**

☐ Treatment goals met; no further services needed

☐ Treatment transferred to: Phone:

☐ Patient or family chose to end services

☐ Patient or family stopped scheduling/coming to appointments

**Note changes in the patient’s functioning since the start of treatment:**

*At home*: ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

*At school:* ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

*With peers:* ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

***Description of progress or deterioration in functioning*:**

**Aftercare Recommendations (if any):**

1. Contact person/Contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Contact person/Contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Contact person/Contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral Health Provider Signature Date**