12 And Beyond

Behavioral Health PHP/IOP Discharge Plan
1230 Fryar Avenue, Sumner, WA 98390

Patient Information

Patient Name: _____
Date of Admission: _____
Date of Discharge: _____
Primary Diagnosis: _____
Secondary Diagnosis: _____
Primary Counselor: _____

Discharge Status:
☐ Successfully Completed Treatment
☐ Administrative Discharge
☐ Against Clinical Advice
☐ Transfer to Higher Level of Care
☐ Transfer to Lower Level of Care
☐ Other: _____

Reason for Discharge

☐ Treatment goals substantially achieved
☐ Stable psychiatric symptoms
☐ Sustained abstinence from substances
☐ Transition to outpatient level of care
☐ Relocation
☐ Non-compliance with treatment requirements
☐ Other: _____

Treatment Summary

Mental Health Progress:
_____

Substance Use Recovery Progress:
_____

Medication Compliance:
_____

Strengths Identified:

_____

Current Clinical Status

Mental Health:

☐ Stable ☐ Improved ☐ Requires Continued Monitoring ☐ Higher Level of Care

Substance Use:

☐ Maintaining Sobriety ☐ Early Recovery ☐ At Risk for Relapse

Risk Assessment:

☐ No SI ☐ Passive SI ☐ Active SI

☐ No HI ☐ HI Present

☐ No Psychosis ☐ Psychosis Present

Risk Level: ☐ Low ☐ Moderate ☐ High

Continuing Care Recommendations

☐ Individual Therapy

☐ Psychiatric Medication Management

☐ Case Management

☐ Family Therapy

☐ Peer Support Services

☐ AA / NA / SMART Recovery

☐ Sober Living

☐ Residential Treatment

☐ PHP

☐ IOP

Recommended Frequency: _____

Follow-Up Appointments

Therapist:

Provider: _____

Date/Time: _____

Psychiatric Provider:

Provider: _____

Date/Time: _____

Primary Care Provider:

Provider: _____
Date/Time: _____

Medication Plan

Medication	Dosage	Frequency

Relapse Prevention Plan

Triggers:
1. _____
2. _____
3. _____

Warning Signs:
1. _____
2. _____
3. _____

Coping Skills:
1. _____
2. _____
3. _____

Recovery Supports:
1. _____
2. _____
3. _____

Crisis and Emergency Plan

In case of crisis:
- Call 911 if immediate danger exists.
- Contact local crisis services.
- Present to the nearest emergency department.
- Contact therapist, psychiatrist, sponsor, or recovery support person.

Emergency Contact:
Name: _____
Relationship: _____
Phone: _____

Discharge Criteria Met

☐ Improved emotional regulation
☐ Increased coping skills
☐ Reduction in psychiatric symptoms
☐ Improved recovery engagement
☐ Ability to function safely in the community
☐ Understanding of relapse prevention strategies
☐ Understanding of crisis response procedures

Signatures

Patient Signature: _____ Date: _____

Primary Therapist: _____ Date: _____

Clinical Supervisor: _____ Date: _____

Medical Provider: _____ Date: _____