PerformCARE®

ACT/CTT Discharge Template

Member Name: ______________________________ Admit Date: ________________________
Address:____________________________ Discharge date: ____________________________
Phone Number: ___________________ Date of last contact: ________________________
Member's mental status at time of last contact: _______________________________________
Discharge reason: ____
Diagnosis at time of discharge: ____

Medications at time of discharge:

Medication Name	Dosage	Frequency /Schedule	Reason for Medication/Special Instructions	Rx given to or name of pharmacy called	Prescriber name/agency/ contact Info

Community Supports for Member to use after discharge:

1. AA/NA group: ____
2. Recovery Specialist: _____________________________________
3. Housing Information: ____________________________________
4. Employment: ____
5. Volunteer Opportunities: _________________________________
6. Education Information: __________________________________
7. Recovery supports and their contact information (such as sponsors, family, friends):
8. Support groups/treatment providers related to specific trauma concerns:
9. Other supports/referrals:

Aftercare Appointments:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
Type of appointment (MAT, trauma, PCP, MH, SU)				
Provider/Clinic Name				
Address				
Phone #				
Date of Appointment				
Time				
Transportation to appointment via:				

*If no aftercare was scheduled, please specify why: ___________________________________

Goals completed while in ACT/CTT:

Finalized Crisis Safety Plan (including coping skills, triggers, supports):