

**THE CENTER FOR DRUG-FREE LIVING, INC.**

**Outpatient Program**

**DISCHARGE SUMMARY**

Client Name:		Client #:
DOB:	SS #:	Telephone #:
Address:		
Placement Date:		Discharge Date:

<b>Discharge Diagnostic Impressions:</b>	
Axis I	V71.09 No Diagnosis, At Risk V71.09 No Diagnosis, At Risk -
Axis II	799.9 Diagnosis Deferred
Axis III	
Axis IV	V71.09 No diagnosis
Axis V	GAF =

**Reason for Discharge:**

**Drug/Alcohol Free For Past 30 Days?**     Yes     No

**Employed**  Yes     No    **If no reason: Unemployable due to mental capacity**

**Services Provided:**

<input type="checkbox"/> Breathalyzer	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Family Sessions
<input type="checkbox"/> Group Sessions	<input type="checkbox"/> HIV Education	<input type="checkbox"/> Individual Sessions
<input type="checkbox"/> Life Skill Sessions	<input type="checkbox"/> Medical/Psych Service	<input type="checkbox"/> Parenting Sessions
<input type="checkbox"/> School/GED	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Vocational Education

**Other:** \_\_\_\_\_

## TREATMENT SUMMARY

Summary of the client's overall performance in the treatment experience with client strengths, needs, and outcomes.

**Anticipated Outcome/Prognosis:**  Excellent  Good  Fair  Guarded

\_\_\_\_\_

**Recommendations:** \_\_\_\_\_

**Specific referrals / transfer made:** \_\_\_\_\_

**Client Readiness to Change Substance Use:**

Pre-contemplation  Contemplation  Preparation  Action  Maintenance

\_\_\_\_\_  
**Primary Counselor Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinical Manager**

\_\_\_\_\_  
**Date**