The Holman Group
Managed Behavioral Health Care Services

Discharge Summary

Please retain in patient's file and send a copy to The Holman Group.

Patient's Name (please print): _____

Insured's Name: _____ Company Name: _____

Insured's Social Security #: _____ Intake Date: _____ Discharge Date: _____

Therapist's Name: _____ License #: _____ Signature: _____

Primary Presenting Symptoms (0 - 5 severity):	Symptoms at Discharge (0 - 5 severity):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

(Severity - 0 = no symptoms, 5 = severe symptoms)

Treatment Modalities: Individual _____ Group _____ Residential Treatment _____ Medication _____
Day Treatment _____ Conjoint _____ Other (specify) _____

Main Treatment Goals (throughout treatment period)	Treatment Results (degrees of treatment success 0 - 5)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

(Degree of Treatment Success - 0 = no success, 5 = goal acheived)

Reason for termination: _____

Psychotropic medications Used During Treatment:

Name/dosage: _____

_____

Medication Still in Use at Discharge:

Name/dosage: _____

_____

Diagnosis upon discharge:

Axis 1: ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___

Axis 2: _____

Axis 3: _____

Axis 4: Psychological Stressors: _____

Axis 5: Current GAF: _____ Highest GAF Past Year: _____

Discharge Plan (Include referrals, family involvement and if further treatment may be indicated): _____

_____

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