

Client's Name: _____
 ID / CR#: _____
 CC / SSC: _____
 Date of Admission (date of registration): _____

TIFFE Staff: _____
 TIFFE / MST Case #: _____
 FGC / School / Program: _____
 Official Closing Date (last billing date): _____

Presenting Condition / Diagnosis: _____

A. Type of Services: Please check all services received during this admission.

DOE Assessment

- 1=EBA Comprehensive
- 2=EBA Annual
- 5=FBA

DOE Psychiatric

- 20=Psychiatric Diagnostic Evaluation
- 21=Psychiatric Mediation Evaluation
- 23=Psychiatric Medication Management

- EIS (DOH)
- Other: _____

DOE Intensive

- 68=IISC – Individual
- 69=IISC - Group
- 71=Parent Education/Training
- 65=Skills Training – Individual
- 70=Skills Training – Group

DOH - CAMHD

- 13101
- MST
- Assessment & Outpatient (list codes): _____

B. Transfer or Discharge: Please check one, "transfer" or "discharge".

- Transfer of Case within TIFFE

Reason for transfer: Change in clinical staff Change in level of care
 Transferred to: _____
Name of TIFFE staff or new level of care (notate service code)

If this is a transfer, Sections C - L do not apply. Complete Section M, sign and date form, and submit to supervisor.

- Discharge

Reason For Termination (check as many as applicable):

- Client Has Met Treatment Goals
- Client Transitioning to School-Based/CBI Services
- Client Terminated due to (circle reason): Non-Cooperation / Refusal of Services / Refusal to Engage
- Elopement of Client
- Client Needs Urgent / Crisis Services
- Client Referred to Another Agency
- Client / Family Requested Termination of Services / Rescinded Consent
- Family Moved
- Client Incarcerated / Residential Treatment Facility
- Other: _____

C. Pre & Post-Test Outcomes: Please attach completed post-test to this summary and fill in scores below.

		Pre-Test Scores	Post-Test Scores
For DOH-13101/MST :	CAFAS family functioning	_____	_____
	CAFAS personal functioning	_____	_____
For DOE Intensive:	ATEC	_____	_____
For EIS:	HELP	_____	_____
Other (describe) _____:		_____	_____

Client Name: _____

CR / ID#: _____

D. Discharge Outcomes (for discharges only): Please circle "Yes", "No", or "N/A".

Did the client's school attendance improve by 10% or more over school attendance at admission? **Yes** **No** **N/A**

Did the client participate in at least one school and/or community activity? **Yes** **No** **N/A**

At discharge, was the client living at home and / or was able to remain out of "placement" by any agency? **Yes** **No**

TIFFE's decision to discharge client was in agreement with the advice of the Family Guidance Center. **Yes** **No**

E. Goals and Progress:

*Circle the percentage of initial treatment/service plan goals that were either fully or partially met. If the actual percentage falls between those listed, circle the closest lower percentage: **100%** **90%** **75%** **50%** **25%** **0%***

F. Client / Family Strengths:

G. Client / Family Needs:

H. Client / Family Abilities:

I. Client / Family Preferences:

J. Medications:

Client Name: _____

CR / ID#: _____

K. Recommendations:

L. Referrals to Community Resources:

M. Was this transfer or discharge discussed with the Client / Family? Yes No

If "yes", transfer / discharge was discussed by: Phone Face-to-Face Date: _____

TIFFE Staff: _____

Date: _____

Supervisor: _____

Date: _____

For Office Use Only:

Reg. Data _____

Master Client List _____ *Satisfaction Surveys* _____