Discharge Guide

When a client drops out of service or has not shown, use the last known information about the clients situation when entering discharge information. Sometimes this information will be the same as the admission information.

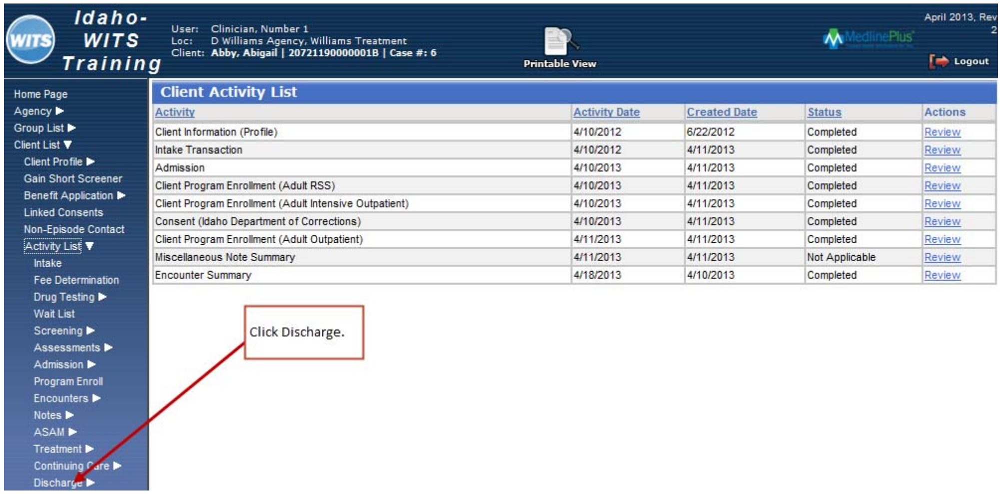
1. **Getting here:** Login, select the **Facility**, select **Client List** from left menu to generate the Client Search Screen, find client, select **Activity List**.

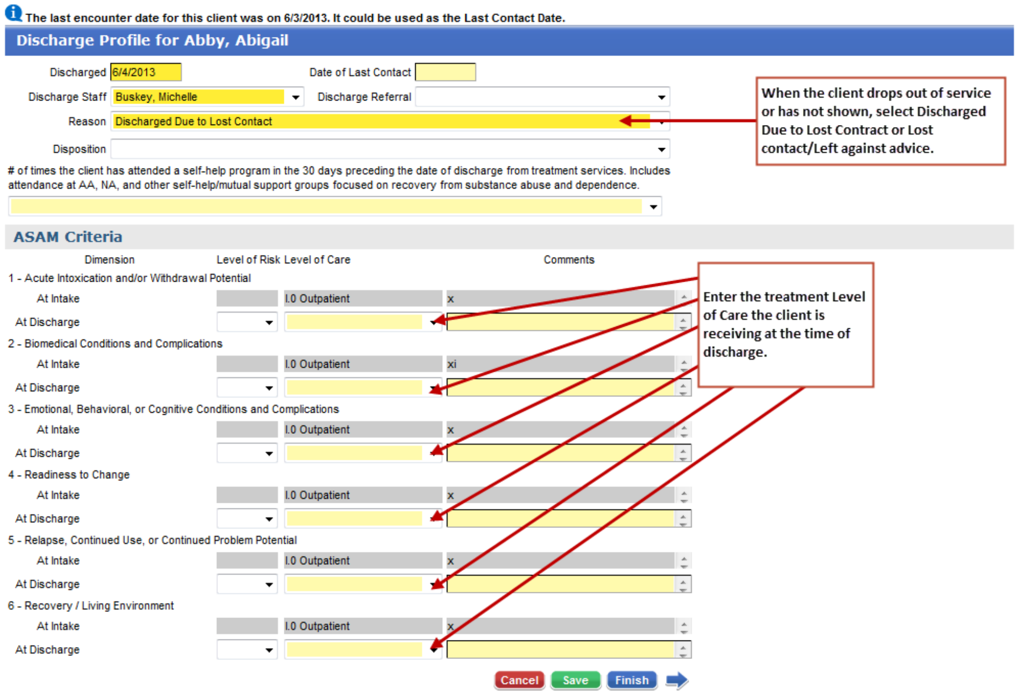
2. Click **Discharge**.

3. Update **Discharged** if needed (the date defaults to the end date of the last Program Enrollment). Complete the **Date of Last Contact**. Update the Discharge Staff and the Reason if necessary (the Reason defaults to the Disenrollment Type selected on the last Program Enrollment). Complete **# of times the client has attended a self-help program in the 30 days preceding the date of discharge from treatment services**.

4. Enter the **ASAM Level of Care** and **Comments** for each Dimension.

5. Click ➡ .





6. Update the **# of Arrests in 30 days before Discharge**.

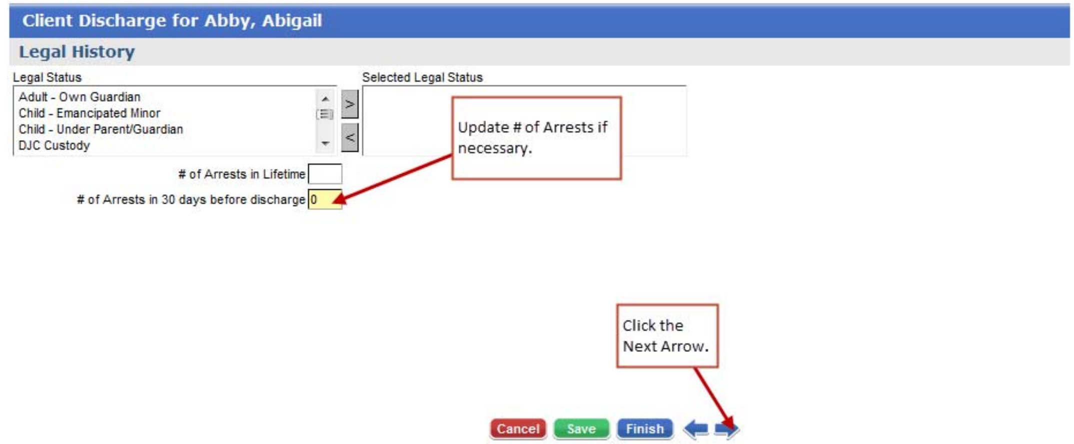
7. Click .

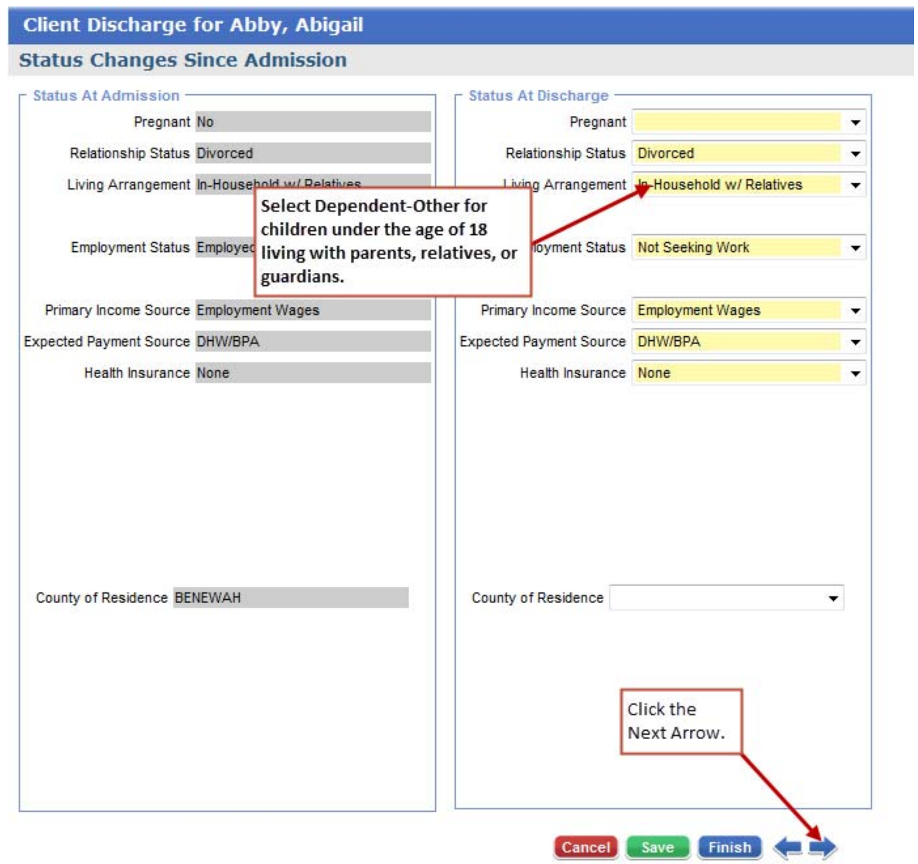
8. Select the **Pregnant** status if applicable.

9. Update the **Relationship Status**, **Living Arrangement**, and **Employment Status**.

10. Select the **Primary Income Source**, **Expected Payment Source**, and **Health Insurance**.

11. Click .





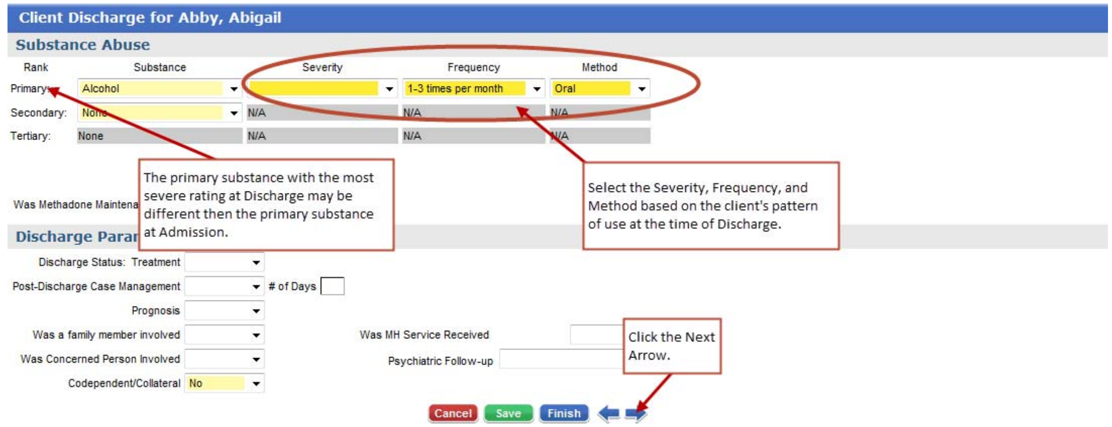
12. Update the **Substance**, **Severity**, **Frequency**, and **Method** for each substance.

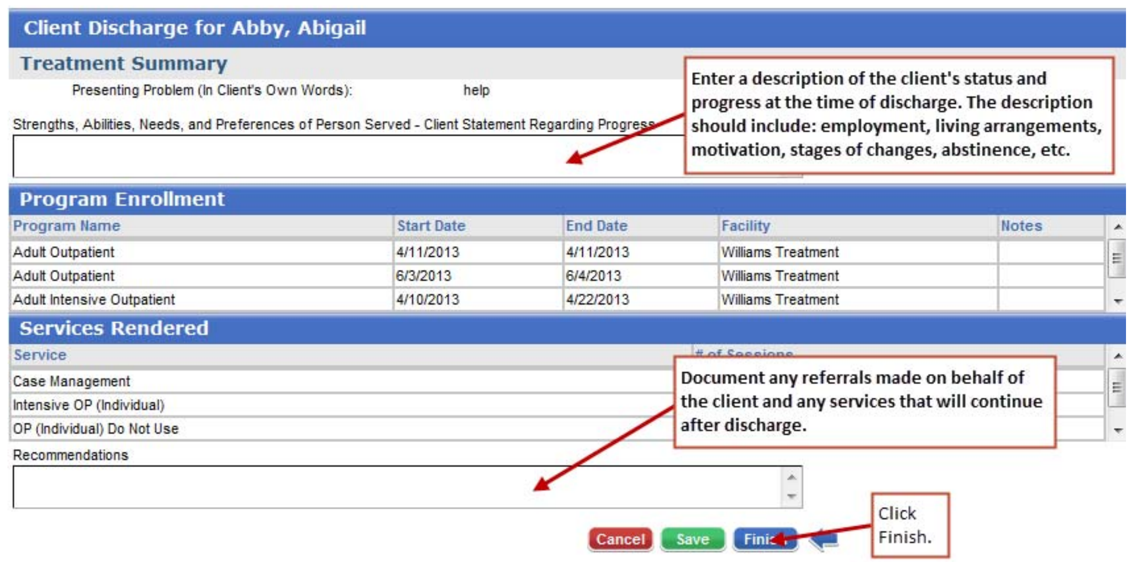
13. Click ➡ .

14. Enter **Strengths, Abilities, Needs, and Preferences of Person Served**. Include a description of the client's status and progress at the time of discharge.

15. Enter **Recommendations** for referrals made on behalf of the client and any services that will continue after discharge.

16. Click Finish.





17. Select **Yes** or **No**.