|  |  |  |
| --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**Division of Care and Treatment ServicesF-01341 (09/2016) |  | Treatment Team Members Present: |
|  | [ ]  Unit Manager |
| **PRE-RELEASE FROM INSTITUTION CHECKLIST** | [ ]  Social Worker |
| **(CM CHECKLIST)** | [ ]  Psychiatrist |
|  | [ ]  Nurse |
| Client Name | Date | [ ]  AODA |
|       |       | [ ]  Rehab Staff |
| [ ]         |
|  |
| **MEDICAL** |
| **Prescribed Medications** |
| [ ]  | Obtain most recent list medications from MHI |
| [ ]  | Medication schedule: |       |
|  |  |       |
| [ ]  | Meds simplified: |       |
| [ ]  | Injectable or quick dissolve available: |       |
| [ ]  | Frequency: |       |
| [ ]  | Side effects? [ ]  Yes [ ]  No |
| [ ]  | If yes, how are the side effects treated: |       |
| [ ]  | Any prescribed PRNs: |       |
| [ ]  |  If yes, how are they managed in the community: |       |
| [ ]  | Blood draw requirements/frequency: |       |
| [ ]  | Name of pharmacy to be used: |       |
| [ ]  | How many day supply: |       |
| [ ]  | Prescription written? [ ]  Yes [ ]  No |
| [ ]  | Administer meds independently? [ ]  Yes [ ]  No |
| [ ]  |  If yes, how long? |       |
| [ ]  | Medication allergies: |       |
|  |       |
| **General Health** |
| [ ]  | Conditions: |       |
| [ ]  | Treatment: |       |
| [ ]  | Dietary needs/restrictions: |       |
| [ ]  | Vitamins/supplements/non-prescription medications: |       |
|  |       |
| [ ]  | Doctor/Hospital: |       |
| [ ]  | Independent health management? [ ]  Yes [ ]  No |
| [ ]  | If no, assistance needed: |       |
| [ ]  | Smoker? [ ]  Yes [ ]  No [ ]  Quit-How Long? |       |  |
| **Medical Equipment** |
| [ ]  | Diabetic supplier: |       |
| [ ]  | CPAP needs: |       |
| [ ]  | Inhalers: |       |
| [ ]  | Other supplies: |       |
| [ ]  | Medical condition related to mental health issues: |       |
|  |
| **CLIENT IDENTIFICATION** |
| [ ]  | State ID card: |       |
| [ ]  | Driver’s license |       |
| [ ]  | Birth certificate: |       |
| [ ]  | Social Security Card: |       |
|  |
| **FINANCIAL INFORMATION** |
| [ ]  | Social Security benefits: |       |
| [ ]  | MA/T19: |       |
| [ ]  | VA benefits: |       |
| [ ]  | Need Payee? [ ]  Yes [ ]  No |
| [ ]  | If yes, previous payee: |       |
|  |
| **INSTITUTION TREATMENT / WORK HISTORY** |
| [ ]  | Work records/vocation assessment: |       |
|  |       |
|  |       |
| [ ]  | Wages earned: |       |
| [ ]  | Independent living skills: |       |
|  |       |
|  |       |
| [ ]  | Leisure interest: |       |
|  |       |
| [ ]  | AODA treatment: |       |
| [ ]  | Relapse Prevention Plan/WRAP completed? [ ]  Yes [ ]  No - Copy available? [ ]  Yes [ ]  No |
|  |
| **CLIENT PROPERTY** |
| [ ]  | Guardian: |       |
| [ ]  | General contents: |       |
|  |       |
| [ ]  | Transportation of property: |       |
|  |
| **OTHER** |
| [ ]  | Release information:  |       |
|  |       |
|  |       |
| [ ]  | Community support:  |       |
|  |       |
|  |       |
|  |
| **DISCHARGE ARRANGEMENTS/RECOMMENDATIONS** |
| [ ]  | Discharge date: |       |
| [ ]  | Discharge destination: |       |
| [ ]  | Discharge transportation: |       |
| [ ]  | Conditional Release Rules signed? [ ]  Yes [ ]  No |
|  |  |