Print Form

DELAWARE DIVISION OF SUBSTANCE ABUSE
AND MENTAL HEALTH
CONSUMER REPORTING FORM
HOSPITAL DISCHARGE REPORT

ADMISSION DATE / /

DISCHARGE DATE / /

TREATMENT UNIT NAME _____

LAST NAME _____

FIRST NAME _____ M.I. ____

TREATMENT UNIT ID # -

MCI # 0 0 0

DISCHARGE REASON

[ ] **G** PROGRAM COMPLETED HERE - ALL GOALS
[ ] **S** PROGRAM COMPLETED HERE - SOME GOALS
[ ] **E** ELIGIBILITY LAPSED
[ ] **D** CONSUMER DIED
[ ] **F** FAILED TO MEET CRITERIA
[ ] **A** ADMIN. DISCONTINUATION/ LOSS OF CONTRACT
[ ] **C** CORRECTION/JAIL
[ ] **R** REFUSED SERVICE
[ ] **T** TX CONT. OTHER PROGRAM
[ ] **O** OTHER
[ ] **U** UNKNOWN

DRUG USE REDUCED

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN
[ ] **X** NOT APPLICABLE

PRIMARY DEST./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICES
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

SECOND. DEST./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICES
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

TERTIARY DEST./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICES
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

PERSON COMPLETING FORM _____ ID

DATE OF COMPLETION / /