**DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH**

**CONSUMER REPORTING FORM**

**HOSPITAL DISCHARGE REPORT**

**PAGE 1 OF 1**

<table>
<thead>
<tr>
<th>TREATMENT UNIT NAME</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>M.I.</th>
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**DISCHARGE DATE**

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**TREATMENT UNIT ID #**

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**MCI #**

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**ADMISSION DATE**

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**DATE OF COMPLETION**

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**DISCHARGE REASON**

- [ ] G PROGRAM COMPLETED HERE - ALL GOALS
- [ ] S PROGRAM COMPLETED HERE - SOME GOALS
- [ ] E ELIGIBILITY LAPSSED
- [ ] 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

**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

**DRUG USE REDUCED**

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

**PERSON COMPLETING FORM**

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**DOCUMENT NO.** 35-06-10-1-20-10