



DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

CONSUMER REPORTING FORM INTRA-AGENCY TRANSFER REPORT

PAGE 1 OF 1

PRIOR TREATMENT UNIT NAME
PRIOR TREATMENT UNIT ID #

Form fields for prior treatment unit name and ID number

LAST NAME

FIRST NAME M.I.

TRANSFER DATE

Form fields for transfer date

NEW TREATMENT UNIT NAME
NEW TREATMENT UNIT ID #

Form fields for new treatment unit name and ID number

MCI #

MCI # form fields

REASON FOR TRANSFER

- [ ] FUNDING CHANGE
[ ] LOC - LEVEL OF CARE CHANGE (HIGHER LEVEL OF CARE)
[ ] LOC - LEVEL OF CARE CHANGE (LOWER LEVEL OF CARE)
[ ] RELOCATION (GEOGRAPHICAL MOVE)

DISCONTINUATION REASON

- [ ] G PROGRAM COMPLETED HERE - ALL GOALS
[ ] S PROGRAM COMPLETED HERE - SOME GOALS
[ ] T TX. CONTINUED IN OTHER PROGRAM

MODALITY

- [ ] MH MENTAL HEALTH
[ ] AD ALCOHOL/DRUG
[ ] DU CO-OCCURRING (MH & AD)

SOFTWARE DEVELOPMENT INSTRUCTIONS

- WHEN CREATING ADMISSION DATE, ADD A DAY
• BOTH "SOURCE / AGENCY CODE" AND "PRIMARY DESTINATION / AGENCY CODE" WILL BE "T" TRANSFERRED
• PULL "MOST RECENT" INFORMATION FOR BOTH ADMISSION AND DISCHARGE RECORDS, FROM THE EPISODE, OR SERVICE TABLE, AS APPROPRIATE
• FOR USE BY AUTOMATED AGENCIES ONLY - DO NOT USE IF PAPER ADMISSION AND DISCHARGE CRF FORMS ARE USED, OR IF YOUR AGENCY IS USING THE CIM SOFTWARE

PRIMARY THERAPIST

ID NUMBER

ID NUMBER form fields

PERSON COMPLETING FORM

ID NUMBER

ID NUMBER form fields

DATE OF COMPLETION

DATE OF COMPLETION form fields