CHILD DISCHARGE REPORT  
(TCU WOMEN AND CHILDREN RESIDENTIAL FORMS)  

<table>
<thead>
<tr>
<th>SITE #:</th>
<th>CHILD ID#:</th>
<th>MOTHER ID#:</th>
<th>COUNSELOR ID#:</th>
<th>TODAY’S DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[6]</td>
<td>[7-10]</td>
<td>[11-14]</td>
<td>[15-16]</td>
<td>[17-22]</td>
</tr>
</tbody>
</table>

Is this form being completed by the case manager? 0=No 1=Yes [23]

ADMISSION DATE: [24-29]

OFFICIAL DISCHARGE DATE: [30-35]

TOTAL DAYS IN PROGRAM: # DAYS [36-38]

1. **REASON FOR DISCHARGE:**  
   Please indicate the reason that the child was discharged from the program.
   
   1. Discharged with mother (irrespective of reason for mother’s discharge)
   2. Discharged without mother (mother’s decision)
   3. Discharge without mother (not mother’s decision)
   4. Death
   5. Other (specify)  

*IF REASON IS DEATH:

   a. Date of death [40-45]
   b. Place of death [COUNTY STATE]
   c. Cause of death (ICD-9 code) if possible  

2. Date of last counseling session? [46-51]

3. Date Aftercare and Discharge Plan completed and signed? [52-57]
4. Are all required TCU Discharge forms completed? ..........0=No 1=Yes 7=Unsure [58]

5. ARRANGEMENTS FOR LEGAL CUSTODY AT DISCHARGE

Please indicate to which of the following the child was discharged.

a. Mother.............................................................................0=No 1=Yes 7=Unsure [59]

b. Father .............................................................................0=No 1=Yes 7=Unsure [60]

c. Grandparent(s).................................................................0=No 1=Yes 7=Unsure [61]

d. Other relatives ..............................................................0=No 1=Yes 7=Unsure [62]

e. Children’s Protective Services ........................................0=No 1=Yes 7=Unsure [63]

*IF CPS “YES”:

a. Was child placed in foster care? ....................... 0=No 1=Yes 7=Unsure [64]

f. Other (specify) ____________________________________________ [65]

6. REFERRAL FOR POST TREATMENT SERVICES

Indicate to which of the following services the child was referred.

a. Pediatric.............................................................................0=No 1=Yes 7=Unsure [66]

b. Behavioral counseling/treatment.................................0=No 1=Yes 7=Unsure [67]

c. Mental health counseling/treatment .............................0=No 1=Yes 7=Unsure [68]

d. Special/remedial education.............................................0=No 1=Yes 7=Unsure [69]

e. Specialized medical services.........................................0=No 1=Yes 7=Unsure [70]

f. Other (specify) ____________________________________________ [71]
A. ASSESSMENT OF CHILD’S PROGRESS: ________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

B. SERVICES/THERAPEUTIC TECHNIQUES PROVIDED: _______________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

C. CHILD’S IDENTIFIED NEEDS & PROBLEMS: _____________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

D. CHILD GOALS ___________________________ DISPOSITION __________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

E. COMMENTS: _______________________________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

F. ___________________________ STAFF SIGNATURE ________________________

_________________________________________________________________

DATE