**DISCHARGE REPORT**
*(TCU WOMEN AND CHILDREN RESIDENTIAL FORMS)*

<table>
<thead>
<tr>
<th>SITE #:</th>
<th>CLIENT ID#:</th>
<th>COUNSELOR ID#:</th>
<th>TODAY’S DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MO</td>
</tr>
</tbody>
</table>

Is this form being completed by the case manager? .................................................. 0=No  1=Yes  [19]

ADMISSION DATE: ........................................................................................................... MO  | DAY | YR  [20-25]

OFFICIAL DISCHARGE DATE: .................................................................................................. MO  | DAY | YR  [26-31]

TOTAL DAYS IN PROGRAM: ...................................................................................................... # DAYS [32-34]

**CHILD IDs:** |                          |                          |                          |                          |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>[35-38]</td>
<td>[39-42]</td>
<td>[43-46]</td>
<td>[47-50]</td>
</tr>
</tbody>
</table>

1. **REASON FOR DISCHARGE:** .............................................................................................. [51-52]
   - 1. SUCCESSFULLY COMPLETED treatment  
     (i.e., in counselor’s judgment, client no longer needs drug abuse treatment)
   - 2. TRANSFERRED to another drug abuse treatment agency at client's request
   - 3. TRANSFERRED to another agency because client's non-drug abuse needs  
     (i.e., mental health or physical health issue)
   - 4. LEFT to care for children not eligible for admission to program
   - 5. LEFT against medical advice/clinical staff advice
   - 6. DECEASED
   - 7. HOSPITALIZED
   - 8. INCARCERATED
   - 9. DISCHARGED due to NON-COMPLIANCE with agency rules
   - 10. Completed minimal treatment requirements (Certificate of Completion)
   - 11. Other (Specify) ________________________________________________________________

*IF REASON IS DEATH:*

   a. Date of death ........................................................................................................... MO  | DAY | YR  [53-58]

   b. Place of death ....................................................................................................... COUNTY | STATE

   c. Cause of death (ICD-9 code) if possible .................................................................


2. Date of last counseling session? .................................................................................... MO  | DAY | YR  [59-64]

3. Date locator form updated? ........................................................................................... MO  | DAY | YR  [65-70]
4. Date phase progress report updated? ................................................................. [MO || DAY || YR] [11-16]

5. Date Aftercare and Discharge Plan completed and signed? ................................ [MO || DAY || YR] [17-22]

6. Date TCU Client Surveys completed? ................................................................. [MO || DAY || YR] [23-28]

7. Indicate to which of the following services the client was referred following discharge.

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mental health services ............. 0 1</td>
<td>f. Employment services ............. 0 1</td>
</tr>
<tr>
<td>b. Medical services ..................... 0 1</td>
<td>g. Housing ................................ 0 1</td>
</tr>
<tr>
<td>c. Family counseling .................... 0 1</td>
<td>h. Legal services ..................... 0 1</td>
</tr>
<tr>
<td>d. Parenting ............................. 0 1</td>
<td>i. Other, specify ..................... 0 1</td>
</tr>
<tr>
<td>e. Education/training .................. 0 1</td>
<td>j. Parenting &amp; family ................ 0 1</td>
</tr>
</tbody>
</table>

8. Does client have a full time job? ........................................................................ 0=No* 1=Yes [39]

9. Does client have a part-time job? ........................................................................ 0=No* 1=Yes [40]

*IF “NO”, TO BOTH QUESTIONS:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is client enrolled in a full time education or training program? ....... 0=No 1=Yes</td>
<td>b. Is client actively seeking employment? ........................................ 0=No 1=Yes</td>
</tr>
</tbody>
</table>

10. Does client have confirmed living arrangements at discharge? ................... 0=No 1=Yes [43]

11. At discharge, was client reunified with children who were not in treatment with her? ................................................................. 0=No 1=Yes* [44]

*IF “YES”:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. With how many children? ........................................................................... # CHILDREN [45-46]</td>
<td></td>
</tr>
</tbody>
</table>

12. How many children were in treatment with their mother at discharge? ........... # CHILDREN [47-48]

Circle the most appropriate response options for each item:

13. In your opinion, was treatment successful? .............................................. 1=Successful 0=Unsuccessful [49]

14. In your opinion, is prognosis ......................... 4=Good 3=Fair 2=Poor 1=Guarded [50]
INFLUENCE OF FAMILY & FRIENDS:

Circle your response for each question. Extended family refers to parents, siblings, and other relatives. Friends refer to old friends, new friends, or women the client has met in treatment. Because many of the children may be too young to provide support, “support from children” refers to the mother’s feelings about parental responsibility.

1. Do you think the client’s extended family influenced the client’s decision to leave First Choice? ........................................ 0=No  1=Yes  8=N/A [51]

   *IF “YES”:

   a. Did extended family primarily support drug use, support neither drug use nor abstinence, or support abstinence? ........................................ 0=Support Drug Use  1=Support Neither  2=Support Abstinence [52]

2. Do you think the client’s partner/spouse influenced the client’s decision to leave First Choice? ........................................ 0=No  1=Yes  8=N/A [53]

   *IF “YES”:

   a. Did partner/spouse primarily support drug use, support neither drug use nor abstinence, or support abstinence? ........................................ 0=Support Drug Use  1=Support Neither  2=Support Abstinence [54]

3. Do you think the client’s children influenced the client’s decision to leave First Choice? ........................................ 0=No  1=Yes  8=N/A [55]

   *IF “YES”:

   a. Did children primarily support drug use, support neither drug use nor abstinence, or support abstinence? ........................................ 0=Support Drug Use  1=Support Neither  2=Support Abstinence [56]

4. Do you think the client’s friends influenced the client’s decision to leave First Choice? ........................................ 0=No  1=Yes  8=N/A [57]

   *IF “YES”:

   a. Did friends primarily support drug use, support neither drug use nor abstinence, or support abstinence? ........................................ 0=Support Drug Use  1=Support Neither  2=Support Abstinence [58]
CLIENT CHARACTERISTICS:

Please circle your response for each question:

<table>
<thead>
<tr>
<th>DISAGREE</th>
<th>NOT SURE</th>
<th>AGREE STRONGLY</th>
</tr>
</thead>
</table>

1. The client worked the program in a positive way (sincerely participated) while at First Choice. .................................. 1 2 3 4 5 6 7 [59]

2. At discharge, it seemed likely that the client would stay clean and sober after leaving First Choice. ............ 1 2 3 4 5 6 7 [60]

3. At discharge, it seemed as if the client had made significant changes in her life. ........................................... 1 2 3 4 5 6 7 [61]

A. ASSESSMENT OF CLIENT’S PROGRESS: 

B. SERVICES/THERAPEUTIC TECHNIQUES PROVIDED: 

TCU FORMS/1STCHOIC/DISCHG (9/98) 4 of 5
C. CLIENT’S IDENTIFIED NEEDS & PROBLEMS: 

______________________________

______________________________

______________________________

______________________________

______________________________

D. CLIENT GOALS

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______________________________

E. COMMENTS: 

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F. ____________________________  ____________________________

STAFF SIGNATURE                          DATE