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. DICSCONTINUATION/ LOSS OF CONTRACT
[ ] C CORRECTION/JAIL
[ ] R REFUSED SERVICE
[ ] T TX CONT. OTHER PROGRAM
[ ] O OTHER
[ ] U UNKNOWN

FUNCTIONING IMPROVED

[ ] Y YES [ ] U UNKNOWN
[ ] N NO

DRUG DEPENDENCE REDUCED

[ ] Y YES [ ] U UNKNOWN
[ ] N NO
[ ] 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

PERSON COMPLETING FORM _____ ID ___ ___ ___ ___ ___ ___

DATE OF COMPLETION ___ ___ / ___ ___ / ___ ___