

Prevention Counseling Completion/Discharge & Case Summary Form 2018-2019

Directions: 1. Complete page 1 and 2. 2. Submit a copy of page 1 with monthly stats (by the 3rd of the month following the last individual session) 3. Place original in case record.

Month _____ Year _____ Counselor _____

Location: _____	Participant Identifier Code: _____
Date of 1st Session Following Admission: ____/____/____	
Date of Discharge: ____/____/____ (Last face to face contact, or date <i>within 30 calendar days of last face to face contact</i>)	
Total # Individual Sessions: _____ Total # Group Sessions: _____ Total # Family Sessions: _____	

Completion Reason: (Select one)			
<input type="checkbox"/> Service Plan Completed (achieved all/majority of objectives)	<input type="checkbox"/> Non-Compliance		
<input type="checkbox"/> Services Achieved Maximum Benefit	<input type="checkbox"/> Refuses Referral		
<input type="checkbox"/> School Year Ended	<input type="checkbox"/> Refuses Counseling or Early Intervention Service		
<input type="checkbox"/> Extended Illness	<input type="checkbox"/> No Face-to-Face Contact		
Referral to Service at Completion: (Select the most significant)			
<input type="checkbox"/> None	<input type="checkbox"/> Family Counseling Services		
<input type="checkbox"/> Crisis Services	<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Developmental Disability Services		
<input type="checkbox"/> Other Substance Abuse Early Intervention	<input type="checkbox"/> Health Care Service		
<input type="checkbox"/> Problem Gambling Services	<input type="checkbox"/> Vocational and/or Educational Services		
<input type="checkbox"/> Provider-Developed Intervention	<input type="checkbox"/> HIV/AIDS Education and Risk Assessment		
30-Day Use at Discharge: (Check substances reported in past 30 days or since Admission if Services were for less than 30 days & # of days)			
<input type="checkbox"/> None Reported	<input type="checkbox"/> Crack _____	<input type="checkbox"/> Marijuana (cannabis) _____	<input type="checkbox"/> Hallucinogens _____
<input type="checkbox"/> Alcohol _____	<input type="checkbox"/> Ecstasy (MDMA) _____	<input type="checkbox"/> Tobacco _____	<input type="checkbox"/> Other Drug Use _____
<input type="checkbox"/> Binge Drinking _____	<input type="checkbox"/> Heroin _____	<input type="checkbox"/> Smoking (vaping-cig) _____	
<input type="checkbox"/> Cocaine _____	<input type="checkbox"/> Inhalants _____	<input type="checkbox"/> Prescription Opioids _____	<input type="checkbox"/> Problem Gambling _____

Data Entry Signature: _____	Date Entered: _____
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2018-2019**

Participant Name/I.D. No.	PRU No. and / or Site Name	Date of Discharge
Discharge Summary (must be completed within 20 business days of date of discharge)		
Follow-Up (Within 90 days of case closing, unless case closed in June)		
Initial F/U Date:	Contact Person:	Telephone No.
Method: _____ (i.e. Telephone, face-to-face, etc.) Status:		

Prevention Counselor Signature: _____ **Date:** _____

Signature of Supervisor: _____ **Date:** _____