Prevention Counseling Completion/Discharge & Case Summary Form
2019-2020

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 *within 20 calendar days of last face to face contact)*	
Total # Individual Sessions: ______ **Total # Group Sessions:** ______ **Total # Family Sessions:** ______	

Completion Reason: (Select one)	
☐ Service Plan Completed (achieved all/majority of objectives)	☐ Non-Compliance
☐ Services Achieved Maximum Benefit	☐ Refuses Referral
☐ School Year Ended	☐ Refuses Counseling or Early Intervention Service
☐ Extended Illness	☐ No Face-to-Face Contact
Referral to Service at Completion: (Select the most significant)	
☐ None	☐ Family Counseling Services
☐ Crisis Services	☐ Mental Health Services
☐ Substance Abuse Treatment	☐ Developmental Disability Services
☐ Other Substance Abuse Early Intervention	☐ Health Care Service
☐ Problem Gambling Services	☐ Vocational and/or Educational Services
☐ Provider-Developed Intervention	☐ HIV/AIES 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)			
☐ None Reported	☐ Crack ___	☐ Marijuana (cannabis) ___	☐ Hallucinogens ___
☐ Alcohol ___	☐ Ecstasy (MDMA) ___	☐ Tobacco ___	☐ Other Drug Use ___
☐ Binge Drinking ___	☐ Heroin ___	☐ Smoking (vaping-cig) ___	
☐ Cocaine ___	☐ Inhalants ___	☐ Prescription Opioids ___	☐ Problem Gambling ___

Data Entry Signature: ______________________________ **Date Entered:** ___________________

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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:** _____________________