**PCC/PCP Discharge Summary**

The discharge summary provides an overview of the history of treatment and functioning while in an out-of-home care setting. Each of the following eight (8) content areas, including the bulleted items, should be addressed in the specified list or narrative format. The Agency has the option of using this discharge summary as a form and entering the information in the text boxes or as an outline of content to be covered in the Agency’s preferred format. The discharge summary becomes part of the child’s record and should be sent to the child’s DCBS social service worker on the date of discharge or the following business day in the event of an unplanned discharge.

1. Identifying Data *(List)*

* Name
* Case or client number
* Date of birth
* Age
* Grade level
* Date of admission
* Date of discharge
* CRP level of care upon admission to current placement

1. Background Data *(Narrative)*

* Reason for admission
* Past placements
* Placement disruptions, if applicable, to include reasons for disruptions
* Current living situation, including location, with whom, and length of time child has lived at current placement
* Assessment of the level and type of attachment with current placement
* Siblings, include number, gender, ages, where each sibling lives, and if not with the child, then location and frequency of visitation.
* History of abuse and or neglect, including if the child was a victim or perpetrator
  + If child was the victim, name the perpetrator
  + If child was the perpetrator, name the victim
* History of risk of harm to self or others
* History of alcohol or substance abuse
* History of legal involvement

1. Capacity for Developmental Functioning *(Narrative)*

* Functioning level
* Strengths
* Challenges
* Special developmental needs, if applicable
* I.Q.
* Physical health
* Personal hygiene
* Social functioning
* School functioning, include IEP if applicable
* Language, speech and hearing functioning
* ADL skills
* Independent living skills abilities

1. Clinical Overview *(Narrative)*

* Diagnosis
* Deferred diagnosis
* Identified goals
* Progress on goals
* Past medications, including rationale for child’s use

1. Clinical Course of Treatment *(Narrative)*

* Mode of treatment
* Evidenced based practice(s)
* Interventions that were effective
* Interventions that were not effective
* Barriers to treatment

1. Condition upon Discharge *(Narrative /Listing)*

* Prognosis
* CRP level of care upon discharge
* Current medications, including rationale for child’s use

1. Discharge Placement *(Narrative)*

* Discharge date
* Person or agency where the child was discharged
* Is the discharge placement meeting the permanency plan? If not, why?

1. After Care Plan/Recommendations *(Narrative/Listing)*

* Person/agency responsible for services, tasks, roles, etc. Include the following:
* DCBS
* Foster care agency
* Mental health facility
* Foster parent(s)
* Biological parent(s)
* School
* Other

* Next medical exams, include provider and date/time
  + - Physical
    - Dental
    - Vision
    - Other
* Follow up Appointments/Meetings
  + Scheduled appointments for the child/family, including provider, location, date and time
  + Scheduled meetings for the child/family, including provider, location, date and time