

# CLIENT DATA

NOTE: The most up to date Client Face Sheet and Discharge Summary is present in the Electronic Health Record. This section should contain any past paper Face Sheets and Discharge Summaries for the current program.

# CLIENT FACE SHEET - EHR

2014

- WHEN:** Data is entered into the EHR when a client assignment is opened and when changes to any of the required elements occur. The Face Sheet is populated by information from the Demographic and Diagnosis Forms as well as from assignment/s entered into the Electronic Health Record (EHR). Since the Face Sheet lives in the EHR, and information on the client is updated in real time as data is entered into the EHR, a paper copy of the Face Sheet is not required to be placed in the paper/hybrid chart. The Face Sheet should be reviewed in the EHR on a quarterly basis at a minimum to assure all information is accurate and up to date.
- ON WHOM:** All clients with an open assignment.
- COMPLETED BY:** The EHR generates this printout based on information entered by each program that has an open assignment of the client. Traditionally this is entered by program's data entry/clerical staff.
- MODE OF COMPLETION:** For clients who are not previously opened in the system the following three forms are to be completed and entered into the EHR:
1. Demographic Form
  2. Assignment Form
  3. Diagnosis Form
- For clients who are currently or previously opened in the EHR the following form is to be completed and entered:
1. Assignment Form.
- Additionally, changes in the client status shall be entered into the EHR as they occur.
- Upon closing of an assignment the following form is to be completed and entered:
1. Assignment Form.
- REQUIRED ELEMENTS:** The Demographic, Assignment and Diagnosis Forms must all be completed and entered into the EHR prior to printing the Face Sheet. If any information is not available at intake, it shall be obtained and entered into the EHR as soon as possible.
- NOTE:** This form is not a standard medical record form, therefore program discretion shall be exercised in determining whether to print out and maintain previous face sheets in the paper/hybrid record.

# DISCHARGE SUMMARY - EHR

2012

- WHEN:** When a client is seen five or more times, a discharge summary must be completed. When seen four or less times, a discharge progress note may be completed. The discharge summary must be completed in the EHR within 7 calendar days of the closing of the assignment. The clinician will only have access to the clinical forms for up to 7 days after the assignment is closed.
- ON WHOM:** Clients discharged from treatment at your Unit/SubUnit, or clients not seen for three months, unless the clinician has documented the reason for absence and it is reasonably expected that the client will receive services within six months.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:  
Physician,  
Licensed/Waivered Psychologist,  
Licensed/Registered/Waivered Social Worker,  
Licensed/Registered/Waivered Marriage Family Therapist, or  
Registered Nurse or Nurse Practitioner.  
Co-signatures must be completed for the Discharge Summary to be final approved.
- NOTE:** The Children's System of Care does not allow the Discharge Summary to be completed by a MHRS staff.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

**San Diego County Mental Health Services  
DISCHARGE SUMMARY**

**\*Client Name:** \_\_\_\_\_ **\*Case #:** \_\_\_\_\_

**\*Discharge Date:** \_\_\_\_\_ **\*Program Name:** \_\_\_\_\_

**\*Date of admission:** \_\_\_\_\_

**\*REASON FOR ADMISSION** *Describe events in sequence leading to admission to your program.  
Describe primary complaint upon admission.*

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**COURSE OF TREATMENT**

Client Plan goal(s) were met?

No     Yes     Partially     Client did not return

Significant diagnostic changes during treatment:     No     Yes

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Summary of Services: *Response to treatment/progress, and reason for discharge.*

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Aftercare Plan: *Information provided to client/family at discharge and recommendations.*

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Discharge Reason: *(Select from Reason Table in the instruction sheet)* \_\_\_\_\_

For Other, Specify: \_\_\_\_\_

Housing/Living arrangements at discharge: *(Select from Living Arrangement table listed in the instruction sheet).*

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Substance use treatment recommendations:     Not Applicable     Yes

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**MEDICAL HISTORY**

Medications at Discharge:

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**Client Name:**            **Case #:**

**Discharge Date:**    **Program Name:**

**REFERRAL(S):** *Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.*

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\*Referred to (*Select from Referral List in Instruction Sheet*): \_\_\_\_\_

Appointment Date: \_\_\_\_\_                      Time: \_\_\_\_\_

Client or caregiver declined referral(s)

**Signature of Clinician Requiring Co-signature:**

\_\_\_\_\_  
Signature    Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_                      Anasazi ID number: \_\_\_\_\_

**Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_  
Signature    Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_                      Anasazi ID number: \_\_\_\_\_

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_  
Signature    Date:

Printed Name:                                      Anasazi ID number:

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary**

**San Diego County Mental Health Services  
Discharge Summary  
Instructions**

**Client Name:** This is a Required Field. Enter the client’s name in this space provided.

**Case #:** This is a Required Field. Enter the case number in the space provided.

**Program Name:** This is a Required Field. Enter your unit name and number in the space provided.

**Date of admission:** This is a Required Field. Enter the information in the space provided.

**Date of discharge:** This is a Required Field. Enter the information in the space provided.

**REASON FOR ADMISSION:** This is a Required Field. Describe events in sequence leading to admission to your program. Describe primary complaint upon admission.

**COURSE OF TREATMENT:** Answer question regarding client plan goals by selecting the appropriate check boxes.

Discharge Reason: Enter a reason for discharge by selecting from the Table Below:

<p><b>Reason for Discharge</b>            1-Transferred to a Higher Level of Care            2-Transferred to Same Level of Care            3-Transferred to Lower Level of Care            4-Satisfactorily Achieved Goals            5-Incarcerated            6-Moved Away from Service Area            7-Client/Family Dissatisfied</p>	<p>8-Deceased            9-Patient Left Against medical Advice            10-Client/Family Did Not Return            11-Client Receiving Services/Tx Elsewhere            12-Change in Medical Insurance            13-Transferred for Medical Reasons            14-Other</p>
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For Other, Specify reason.

For significant diagnostic changes select “No” or “Yes” text box is provided for further information. Summary of services text box is provided to record response to treatment/progress and reason for discharge.

Aftercare Plan: Text box is provided for information provided to client/family at discharge and recommendation.

Housing/Living Arrangements at discharge: Entering the appropriate response in the space provided from choices listed in the Table below:

<b>Living Arrangement</b>		
A-House or Apartment	G-Substance Abuse Residential	O-Other
B-House or Apt with Support	Rehab Ctr	R-Foster Home-Child
C-House or Apt with Daily Supervision	H-Homeless/In Shelter	S-Group Home-Child (Level 1-12)
Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	T-Residential Tx Ctr-Child (Level 13-14)
D-Other Supported Housing Program	J-SNF/ICF/IMD	U-Unknown
E-Board & Care – Adult	K-Inpatient Psych Hospital	V-Comm Tx Facility (Child Locked)
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	W- Children’s Shelter
	M-Correctional Facility	

Substance use treatment recommendations: Check boxes “Not Applicable” or “Yes” text box is provided for further information.

## MEDICAL HISTORY

Medications at Discharge: List all medications dispensed or ordered at discharge.

Medication Adherence: Check the appropriate box, and explain in Comments text box as necessary client's compliance with medications.

Allergies and adverse medication reactions: Check "No", "Unknown/Nor Reported" or "Yes". If Yes, specify in comments box.

Other prescription medications: Check "None" or "Yes". If yes, specify in comments box.

Herbal/Dietary Supplements/over the counter medications: Check "None" or "Yes". If Yes, specify in comments box.

Healing and Health: Document in text box any healing and/or health practices made by client.

## HISTORY OF VIOLENCE:

History of domestic violence: Check boxes "None Reported" or "Yes" text box is provided for further information.

History of significant property destruction: Check boxes "None Reported" or "Yes" text box is provided for further information.

History of Violence: Check boxes "None Reported" or "Yes" in text box specify intensity past or current.

History of Abuse: Check boxes "None Reported" or "Yes" in text box specify intensity past or current.

Abuse Reported: Check boxes "N/A", "No" or "Yes", if yes enter information in text box.

Experience of traumatic event(s): Check boxes "No" "Yes" "Unknown/Not Reported" if yes, describe traumatic experience and summarize impact in text box.

**REFERRAL(S):** Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.

Referred To: This is a required field. Select from Table below specific referrals.

<b>Referred To:</b> 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse	6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC	12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None
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If Other, Specify in this field.

In the text boxes enter the appointment date and time, if available. Check the box if client or caregiver declined referral(s).

**SIGNATURES:** Enter the name, credential, date and Anasazi ID number for the clinician requiring a co-signature (if applicable); and/or the clinician completing/accepting the evaluation.

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary.**