



**SUBSTANCE ABUSE PREVENTION AND CONTROL  
DISCHARGE / TRANSFER FORM**

Mail: Substance Abuse Prevention and Control  
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803  
To check submission status call: (XXX) XXX-XXXX

Website: <http://publichealth.lacounty.gov/sapc/>  
Fax: (XXX) XXX-XXXX

<b>1. Name (Last, First, and Middle)</b> Doe, John	<b>2. Date of Birth (MM/DD/YY):</b> 1/1/1989	<b>3. Medi-Cal Number:</b> 123-45-6789
<b>4. Admission Date:</b> 1/21/2016	<b>5. Discharge Date:</b> 6/21/2016	<b>6. Discharge Diagnosis:</b> Opiate use disorder (severe)- early remission

**7. Narrative summary of the course of treatment episode:**  
 Dimension 1: Client has not used opioids since entering treatment and continues to utilize buprenorphine as prescribed.  
 Dimension 2: Client has been referred to pain management specialist and primary care provider to help with his recovery from the accident.  
 Dimension 3: Client continues to attend individual therapy for his mental health issues.  
 Dimension 4: Client is motivated to work on his SUD use, and will continue with outpatient treatment.  
 Dimension 5: Client has been able to control his cravings, through the use of MAT, learned coping skills, and be meeting regularly with NA sponsor.  
 Dimension 6: Client currently lives in a sober living and will need continued support looking for independent housing and employment. He has made improvement with his personal relationships.

**8. Patient's Prognosis:**     Good     Fair     Poor  
**Please explain:**  
 Mr. Doe has not used opioids for 6 months. He has maintained control over his cravings during this time.

**9. Description of relapse triggers and plan to avoid relapse when confronted with each trigger:**  
 Client reported triggers being certain environments and stress from being unemployed and without stable housing. He will avoid relapse through the continue use of MAT, continuing to learn coping skills during outpatient treatment, checking in with NA sponsor at least 1x per week, and continuing to attend and actively participate in NA meetings.

**10. Medications (including dosage & response):**  
 Suboxone (buprenorphine and naloxone) 16mg/ 4 mg once a day. (This is the targeted maintenance dose). He reports better control over cravings while taking this medication.

**11. Reason for Discharge/Referral:**

Completed treatment goals/plan at this level of care  
 Left before completing treatment goals/plan with satisfactory progress  
 Left before completing treatment goals/plan with unsatisfactory progress  
 Discharged by agency for cause (e.g., non-compliance with agency rules)  
 Designated SUD level of care is not available at this time  
 Discharged into more appropriate other system of care  
 Does not meet SUD medical necessity  
 Death [administrative discharge]  
 Incarceration [administrative discharge]  
 Other, Specify:

**12. Recommendations for Follow Up:**  
 Client will be referred to Outpatient SUD treatment to continue to work on relapse prevention. He will continue with MAT as prescribed and will be referred to a case manager with the outpatient SUD provider for assistance with housing and employment. Given ongoing depressive symptoms, will refer for mental health assessment and continue with individual therapy. Client also referred to primary care provider due to ongoing residual pain.

**13. Is a copy of this Discharge/Transfer Form provided to the patient?**  
 Yes     No    Explain:

<b>14. Provider's Name:</b> Greg Lollipop	<b>15. Provider's Signature:</b> <i>Greg Lollipop</i>	<b>16. Date:</b> 6/21/2016
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<small>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.</small>	<b>Client Name:</b> Doe, John	<b>Medi-Cal ID:</b> 123-45-6789
	<b>Treatment Agency:</b> Healing SUD Treatment Center	

**DISCHARGE / TRANSFER FORM INSTRUCTION**

*The discharge plan shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the patient.*

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal identification number.
4. Enter the patient's admission date.
5. Enter the patient's discharge date.
6. Enter the patient's discharge diagnosis.
7. Enter a narrative summary of the treatment episode. Describe services received and the patient's response.
8. Mark the appropriate box for patient's prognosis: "Good", "Fair", or "Poor", and provide an explanation.
9. Enter a description of relapse triggers and plan to avoid relapse when confronted with each trigger.
10. Enter the patient's medications. Include dosage and response.
11. Enter the reason for the discharge/referral. If none of the listed reason is applicable, check "Other" and provide an explanation.
12. Enter any recommendations for follow up including specify referred level/type of care.
13. If a copy of this form is provided to the patient, check "Yes"; otherwise, check "No" and provide an explanation.
14. Print the provider's name.
15. Enter the provider's signature.
16. Enter the date the provider signs the form.

**INTERNAL SAPC USE ONLY**

This section reserved for internal SAPC use only.

***SUBMIT THE DISCHARGE / TRANSFER FORM TO:***

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