The Holman Group
Managed Behavioral Health Care Services

Discharge Summary

Please retain in patient's file and send a copy to The Holman Group.

Patient Name:		**DOB:**	
Insured's Name:		**Company Name:**	
Intake Date:		**Discharge Date:**	
Therapist's Name:		**License#:**	
Therapist's Signature:		**Date:**	

SYMPTOMS AND SEVERITY

Primary Presenting Symptoms (0 – 5 Severity):	**Symptoms at Discharge (0 – 5 Severity):**
(Severity "0" = no symptoms, "5" = sever symptoms)	
1.	
2.	
3.	
4.	
5.	

TREATMENT

Treatment Modalities:	☐Individual	☐Group	☐Residential Treatment	☐Medication
	☐Day Treatment	☐Conjoint	☐Other (Specify):	

Main Treatment (Throughout treatment period)	**Treatment Results (Degrees of treatment success 0 -5)**
Degree of treatment Success "0" = no success, "5" = goal achieved)	
1.	
2.	
3.	
4.	

Reason for Termination

Psychotropic Medications Used During Treatment (Name/ Dosage)

Medication Still in Use at Discharge (Name/ Dosage)

DISCHARGE INFORMATION

Diagnosis Upon Discharge				
Axis 1:				
Axis 2:				
Axis 3:				
Axis 4:	Psychological Stressors:			
Asis 5:	Currant GAF:		Highest GAF Past Year:	

Discharge Plan (Include referrals, family involvement and if further treatment may be indicated)