

OCRP Discharge Summary

| Section 1. Points of Contact | | | |
|---|---------------------|-------------------|---------------------|
| CLIENT'S NAME | PROGRAM END DATE | CAUSE NUMBER(S) | PHONE NUMBER () |
| OCRP PROVIDER'S NAME | | | PHONE NUMBER () |
| DSHS FORENSIC NAVIGATOR'S NAME | | | PHONE NUMBER () |
| FHARPS'S CONTACT OR <input type="checkbox"/> N/A | | | PHONE NUMBER () |
| DISCHARGE STREET ADDRESS | CITY | STATE | ZIP CODE |
| OUTPATIENT BEHAVIORAL HEALTH PROVIDER'S NAME | | | PHONE NUMBER () |
| OUTPATIENT BEHAVIORAL HEALTH CASE MANAGER'S NAME | | | PHONE NUMBER () |
| Section 2. Treatment Summary | | | |
| DISCHARGE DIAGNOSIS | | | |
| DISCHARGE MEDICATIONS | | | |
| REASON FOR DISCHARGE <input type="checkbox"/> Charges dismissed <input type="checkbox"/> Opined not competent <input type="checkbox"/> Return to jail for hearing <input type="checkbox"/> Death <input type="checkbox"/> Opined competent <input type="checkbox"/> Opined not restorable <input type="checkbox"/> Conditions revoked <input type="checkbox"/> Need Inpatient Care <input type="checkbox"/> Other: | | | |
| Progress toward Barriers to Competency (list barriers and interventions / progress) | | | |
| | | | |
| Summary of Overall Program Participation | | | |
| | | | |
| Section 3. Follow Up Care | | | |
| Residence Information | | | |
| PROVIDER'S NAME OR <input type="checkbox"/> N/A | PHONE NUMBER () | FAX NUMBER () | |
| CONTACT PERSONS'S NAME OR <input type="checkbox"/> N/A | | | PHONE NUMBER () |
| COMMENTS | | | |

