[Insert organisation name/logo]

# CLIENT EXIT SUMMARY FORM

This form is to be completed by the client with the support of their allocated staff member. With one copy for the client and a second copy for the organisation.

## SECTION 1. CLIENT DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Reference #** |  |
| **Address** |  | **Date of birth** |  |
| **Phone** |  | **Mob:** |  |
| **Date of intake** |  | **Date of exit** |  |
| **Intake staff member** |  | **Staff member Phone** |  |
| **Reason for intake** |
|  |
|  |
| **Reason for exit** |
| □ Achieving goals □ Problems resolved □ Referral to another organisation □ Client ceased contact □ Client initiated exit □ Client moved □ Unacceptable behaviour □ Client death □ Completed program □ Other, please specify: |
| **How would you rate the service/program\*** |
| □ Very good □ Good □ Neither good or poor □ Poor □ Very poor \*An additional client feedback form is attached to this form as part of the exit process. For more information refer to Section 5 of this document.  |
| **Comments** |
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| **Summary of services provided**  |
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## SECTION 2. CLIENT INFORMATION ON EXIT

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| **Summary of progress and treatment**  |
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| **Medication at exit**  |
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| **Health issues**  |
| **Physical** | **Mental Health** |
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| **Current personal situation**  |
| **Client lives** | **Benefits** | **Education** | **Employment** |
| □ Alone□ With family/carer □ Other Please specify: | □ Yes □ No If so, what type? | □School □University □TAFE □ Other Please specify: | □ Full-time □Part-time □Casual □Seeking employment |
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| **Family and social support** |
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| **Lifestyle activities** |
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| **Legal issues** |
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## SECTION 3. CLIENT REFERRAL

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| **Is the client being referred to another organisation?**  |
| □ Yes □ No If no, go directly to Section N.4. |

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| **Client consent**  |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and agree for **[insert organisation name]** to provide my personal details. I understand my involvement in this process is voluntary and I may withdraw at anytime. I also understand that I can withdraw my consent at any time. I give consent to share information relating to my treatment and support needs.Consent type : □Verbal - Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_Time of consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Written - Time of consent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

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| **Reason for referral**  |
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| **Referral organisation details** |
| **Organisation name** |  |
| **Address** |  |
| **Hours of operation** |  |
| **Name of program** |  |
| **Contact name** |  |
| **Phone** |  | **Mobile:** |  |
| **Date of referral** |  | **Date of entry** |  |

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| **What are my immediate plans if asked to leave, or if I decide to leave this treatment service?** |
| □Stay in the local area □Go back to □Other (specify below) |

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| **Follow-up contact with client**  |
| **Date****[insert due dates]** | **Staff member name**  | **Detail****[insert details of the follow-up]** |
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## SECTION 4. SAFETY PLAN

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| **Whom should I notify when I leave this treatment service?** |
| □Family □Friends □Other (specify below) |

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| **How will I continue to get support for my recovery after I leave this treatment service?** |
| □ 12 Step meetings □ AOD counsellors □ Outreach services  □ General counsellors □ SMART groups □ Other (specify below) |

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| **Suicide prevention, self-harm and risk to others** |
| Suicide screener attached | □ Yes □No |
| Suicide risk formulation template attached | □ Yes □No |
| If no, please explain the reasons |
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| **Suicide prevention**  | **Self-harm** | **Risk to other** |
| □ Low □ Moderate □ High\*\*High risk levels require immediate action, for more information refer to the Client Clinical Management. | □ Low □ Moderate □ High\* | □ Low □ Moderate □ High\* |
| **Comments** |
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| **Other organisations which will continue to be involved through aftercare:** |
| **Org. name** |  |
| **Helps with** |  |
| **When** |  |
| **Where** |  |
| **Staff name** |  | **Phone** |  |
|  |
| **Org. name** |  |
| **Helps with** |  |
| **When** |  |
| **Where** |  |
| **Staff name** |  | **Phone** |  |
|  |
| **Org. name** |  |
| **Helps with** |  |
| **When** |  |
| **Where** |  |
| **Staff name** |  | **Phone**  |  |

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| **What else can I do?** |
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| **How will I get to where I need to go?** |
| □ Bus □ Train □ Air-travel □ Car □ Other (specify below) |

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| **How much money will I need and how will I resource my first few days out of this treatment service?** |
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| **Where will I stay in the short term?**  |
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| **Consider the cost of** | **How will I afford this?** |
| Food □ Yes □ No |  |
| Transport □ Yes □ No |  |
| Accommodation □ Yes □ No |  |
| Medications □ Yes □ No |  |
| Other costs □ Yes □ No |  |

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| **If things go wrong, who will I reach out to and what will I do?** |
| **Emergency accommodation**  |
|  |
| **Medical/mental health (specify doctor, counsellor, hospital etc.)** |
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| **Financial health (e.g. Centrelink)** |
|  |
| **Legal Assistance (eg Legal Aid)** |
|  |
| **Harm minimisation (e.g. Needle Syringe Program, Condoms)** |
|  |
| **Other support** |
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| **Whom should I turn to for assistance such as lifts, accommodation or support? (Provide names and contact details)** |
| **Name** | **Contact details** |
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**SECTION 5. EMERGENCY CONTACT**

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| **Emergency contact details**  |
| **Full name** |  |
| **Relationship**  |  |
| **Address** |  |
| **Phone** |  | **Mobile** |  |
| **Email**  |  |
| **Preferred method of contact**  | □ Mail □ Phone □ Mobile □ Email |

**SECTION 6. CHECKLIST**

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| --- | --- |
| **Section details** | **Complete** |
| **Section 1. Client details** | **□ Yes □ No** |
| **Section 2. Client information on exit** | **□ Yes □ No** |
| **Section 3. Client referral** | **□ Yes □ No** |
| **Section 4. Safety Plan** | **□ Yes □ No** |
| **Section 5. Emergency contact** | **□ Yes □ No** |
| **Information about other service providers**  | **□ Yes □ No** |
| **Organisational information including:*** **feedback and complaints information**
* **How to re-enter the organisation services**
* **Safety strategies hand out ( for people with suicide or self-harm risk)**
 | **□ Yes □ No** |
| **Client and service copy printed**  | **□ Yes □ No** |

|  |  |
| --- | --- |
| **Client name** |  |
| **Client signature** |  |
| **Date** |  |
|  |
| **Staff member name**  |  |
| **Staff member signature**  |  |
| **Date**  |  |