See MHS 150 Legend instructions to complete this form.

Client Medical Record Number:

Discharge Program Name:

Discharge Program RU:

Client Name (Last):

Client Name (First):

Client Name (Middle Int.):

Client Date of Birth: - -

SSN: - -

Date of Discharge: - -

CIN:

Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown

1. Type of Discharge:

Client's Home Phone: - -

Client's Work Phone: - -

Client's Address-Street:

City, Zip & State:

Maiden Name:

4. Alias:

2. Birth Name (Last):

5. Birth Name (First):

3. Mother's First Name:

Assigned Staff #:

6. Marital Status:

10. Client Race:

13. Other Race(s):

7. Primary Language:

11. Education:

14. Employment Status:

8. Ethnic Origin:

12. Smoker:

9. Place of Birth (County Code, State, Country): - -
***

15. Diagnosis: CURRENT DIAGNOSIS USING DSM-5
List Primary Mental health diagnosis first.

ICD-9 Code	ICD-10 Code	
		☐ P

16. Trauma: ☐ Y ☐ N ☐ Unknown

17. Substance Abuse/Dependence: ☐ Y ☐ N ☐ Unknown/Not Reported

Substance Abuse Diagnosis:

18. Diagnosing Practitioner #:

19. General Medical Condition Summary Code:

***IF SONOMA COUNTY DID NOT CONTRACT WITH YOU TO COMPLETE ASSESSMENTS, LEAVE BOXES 15 THROUGH 19 BLANK.

COUNTY OF SONOMA
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
CLIENT EPISODE DISCHARGE

Client Name:

Client #: