[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** | | | | |
| Client ceased contact  Client initiated exit  Client moved  Behaviour  Client death  Completed program  Referral to another organisation    Other, please specify: | | | | |

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| **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 yes, 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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| **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 4 of this form |

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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 any time. 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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| **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 (to be completed with the client)

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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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| **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 after I leave this treatment service?** |
| 12 Step meetings  AOD counsellors  Outreach services    General counsellors  SMART groups  Other (specify below) |

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| **Other organisations which will continue to be involved with continuing care:** | | | |
| **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.)** |
|  |
| **Financial health (e.g. Centrelink)** |
|  |
| **Legal Assistance (eg Legal Aid)** |
|  |
| **Harm minimisation (e.g. Needle and 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** | 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** |
| **Provide information about other service providers** | **Yes**  **No** |
| **Provide organisational information including:**   * **feedback and complaints information** * **How to re-enter the organisation services** | **Yes**  **No** |
| **Client and service copy printed** | **Yes**  **No** |

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