



BEACON HEALTH STRATEGIES
FST DISCHARGE FORM

Provider Information

Provider ID# _____ Provider Name and Site Location _____
Provider Phone # _____ FST Clinician _____
Contact/Supervisor _____

Member Information

Member Name: _____ Date of Birth ____/____/____
Health Plan: NHP Fallon NHPRI Member ID# _____

Diagnosis (Refer to DSM IV) Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: HGAF _____ LGAF _____ CGAF _____

Rate Parental Communication with Child 1 None 2 Minimal 3 Fair 4 Good 5 Excellent
Rate Current Parental Skills 1 None 2 Minimal 3 Fair 4 Good 5 Excellent
Rate Family's Potential for Stabilization 1 None 2 Minimal 3 Fair 4 Good 5 Excellent

Current Medications: Name Dosage and Frequency

PCP contacted: _____ Y _____ N

FST Service Plan: (Status of family functioning, goals achieved, areas for improvement)

Summary Of Services Provided During the FST: (include number of weeks/units used)

Discharge plan: (outpatient tx's and appointments, state agency, community supports)