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)