Discharge Plan and Safety Contract

Person's Name (First MI Last):	**Record #:**	**DOB:**
Organization Name:		

Upon discharge from the Emergency Service Program to the community, the ESP shall provide a written discharge plan to be given to members, family and others as applicable.

Outpatient and PCP follow-up appointments				
Name	Time	Address	Telephone	Date

Medications Ordered During Current Emergency Evaluation:		
Name of medication	Dosage	Instructions

Crisis Plan / Behavioral Interventions:

ESP Telephone:		Follow-up Date and Time:	/

Safety Contract:
By accepting this Discharge Plan, I agree, at this time, not to harm myself or anyone else and remain safe in the community. If, at any time, I should feel like hurting myself, hurting anyone else, being destructive, or unable to keep this contract, I will contact the nearest Emergency Service Program. I understand the ESP evaluating me today is available 24 hours a day and can be reached at .

☐ Treatment objectives discussed with the person served/guardian.

Provider - Print Name/Credential:		**Supervisor - Print Name/Credential** (if needed):	
Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Person's Signature (Optional, if clinically appropriate):	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
MD Signature (Required For Opiate Treatment Programs):	**Date:**	**Next Appointment, if applicable:** **Date: / / - Time:** ☐ **am** ☐ **pm**	

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code