PART 857 PROBLEM GAMBLING OUTPATIENT SERVICES
DISCHARGE PLAN

Patient Name:	Patient ID #:	Admission Date:	Discharge Date:

In preparing this assessment, consideration should be given to: the patient's self-reported confidence in maintaining abstinence; an assessment of the home environment; vocational/educational/employment status; and to establish the level of social services available to the patient and the need for services to significant others and relationships with significant others.

INDIVIDUALIZED RELAPSE PREVENTION PLAN

The Discharge Plan needs to be reviewed and signed by the Responsible Clinical Staff Member and the Supervisor **prior** to patient discharge.

SIGNATURE OF RESPONSIBLE CLINICAL STAFF MEMBER: **DATE:**

SIGNATURE OF CLINICAL SUPERVISOR: **DATE:**

By signing, I attest that I have participated with the treatment staff in the development of this discharge plan:

SIGNATURE OF PATIENT: **DATE:**