

**WVDHHR MR/DD CRISIS RESPITE SITE
INDIVIDUAL DISCHARGE REPORT**

Form C.5.

(Please add narrative summary page.)

DATE OF DISCHARGE: _____		DOB: _____	BED NUMBER: _____
REPORTER: _____		FINAL DESTINATION: _____	
NAME/RESIDENTIAL ADDRESS		TELEPHONE	WVU/CED SERVICES ADDED?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
RECEIVING PERSON/RELATIONSHIP		RESPONSIBLE AGENCY	TELEPHONE
OUTCOMES	DISCHARGED TO:	GUARDIANSHIP TYPE	DISCHARGE RECOMMENDATIONS
<input type="checkbox"/> Medical Needs <input type="checkbox"/> Stable <input type="checkbox"/> Not Stable <input type="checkbox"/> Behavioral Support Needs <input type="checkbox"/> Stable <input type="checkbox"/> Not Stable <input type="checkbox"/> Housing Needs <input type="checkbox"/> Stable <input type="checkbox"/> Not Stable <input type="checkbox"/> Social Needs <input type="checkbox"/> Stable <input type="checkbox"/> Not Stable	<input type="checkbox"/> Independent Living <input type="checkbox"/> Semi Independent Living <input type="checkbox"/> AFC/SFC/FC <input type="checkbox"/> Natural Family <input type="checkbox"/> MR/DD HCB Waiver <input type="checkbox"/> ISS/Group Home <input type="checkbox"/> ICF Group Home <input type="checkbox"/> SNF/Nursing Home <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Out of State Hospital <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other _____ SPECIFY: _____ _____ _____	<input type="checkbox"/> Self <input type="checkbox"/> Surrogate <input type="checkbox"/> Limited <input type="checkbox"/> Ad Litem <input type="checkbox"/> Full <input type="checkbox"/> Conservator <input type="checkbox"/> POA <input type="checkbox"/> Payee <input type="checkbox"/> Guardianship Changes <input type="checkbox"/> Other _____ <hr/> COMMENTS: _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Advocacy <input type="checkbox"/> Linkage/Referral/Training <input type="checkbox"/> Positive Behavioral Support <input type="checkbox"/> WVU CED _____ <input type="checkbox"/> Increase Level of Care/Service <input type="checkbox"/> Maintain Level of Care/Service <input type="checkbox"/> Reduce Level of Care/Service <input type="checkbox"/> Futures Planning <input type="checkbox"/> Medical Support <input type="checkbox"/> General Health <input type="checkbox"/> Diet/Nutrition <input type="checkbox"/> Ear Care <input type="checkbox"/> Eye Care <input type="checkbox"/> Seizure Care <input type="checkbox"/> PT, OT, Speech, Therapies <input type="checkbox"/> Med Checks/Nursing <input type="checkbox"/> Counseling <input type="checkbox"/> Other _____