CAMHS Inpatient Discharge Summary

Child/Young Person's Details	
Name:	
Address:	
Phone Number:	Date of Birth:
Gender :	Nationality:
PPSN:	

Consultant Psychiatrist Details:	
Name:	MCRN:
Address:	
Phone Number:	Email address:

GP Details:	
Name:	
Address:	
Phone Number:	

Keyworker's Details:	
Name:	
Job title:	
Phone Number:	Email address:

Name: Date of Birth:

Admission Details:
Date of admission:
Approved Centre name:
Unit Name:
Reason for Admission:
Legal Status:

Discharge Planning Details:
Date of Discharge planning meeting:

Who Attended Discharge Planning Meeting:
Discharge Planning Meeting Included Community CAMHS Team Member: Yes ☐ No ☐
If yes, name(s) of attendee(s):
Name of Parent(s)/Guardian(s) Who Attended Discharge Planning Meeting:

Discharge Details:
Follow-Up Community CAMHS Appointment – Date & Time:
Community CAMHS Team Name and Contact Number:
Discharge Destination: (Where is the young person being discharged to?)

Psychiatry Summary:

Name: Date of Birth:

Nursing Summary:

Keyworker Summary:

Multidisciplinary Team (MDT) Summary:
Discharge Diagnosis (ICD-11):
Date of Discharge:

Brief in Patient Care Summary:

Name: Date of Birth:

Diagnostic Formulation, Recovery Journey and Outcomes(s)

Discharge Medications:

Physical status on Discharge:

Known Allergic Reaction(s):

Mental State at Discharge:

Name: Date of Birth:

Management Advice / Follow-Up Arrangements:	
Discharge Safety Plan Completed:	Yes ☐ No ☐
Information Given to Young Person & Parent(s)/Guardian(s)	Yes ☐ No ☐
Other relevant information:	

Other Agencies- Contact Details and Nature of Involvement:	**Summary of Involvement:**

Risk Issues and Safeguarding Concerns:
Risk Issues:
Are there any current or historical safeguarding concerns that should be considered as part of discharge planning? Yes ☐ No ☐ If yes, please provide details and any actions taken or required
Signed:
Print name:
Job title:
Contact Details:
Date & Time: