Transition Planning Form

Client Name: _____ MPI #: _____ Start Date: _____ Projected Discharge: _____

Clinical Team: _____ Team Leader: _____ Clinician: _____

PNP Provider: _____ Contact: _____ CVH Contact: _____

DOMAIN		***ISSUE***	***Person Responsible/Date***
Engagement	Clinical Team	• The team has met with the person 4 or more times and feels that a good relationship has been established • The clinician has met with the client 4 or more times and believes there is good communication and the foundation for trust and honesty • The person has visited the clinic setting and expressed agreement • The person has met with their community prescriber	
	PNP Provider	• The PNP has met with the person 2 or more times and feels that a good relationship has been established • The PNP believes the person has a good understanding of the community setting and is committed to trying to make it work • The person has visited the community setting and expressed agreement	
Relationships & Support Network	Family/Friends	• The family accepts the person has a behavioral health illness and understands the impact of the behavioral health illness on community behaviors • The family is willing to join with the team and will participate in interventions to interrupt behaviors, as needed • The person has identified 1 or more friends/peer support staff with whom they can engage and/or identified a social activity in which they will participate on an on-going basis • If the person has a conservator of person, the conservator has been included in planning and agrees with the plan	
	Community Culture	• If the person has been in the hospital for 2 or more years: 1. They can participate in appropriate leave-taking from CVH staff 2. They are oriented to current culture (How has the community changed since they last live there?) • The person has identified their plan to celebrate their release	

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		• The person and their clinician have discussed the concept of "reality let-down" post discharge from the hospital	
Motivation to Change		• Level of motivation to change has been carefully assessed and addressed in treatment and discharge planning • Areas of ambivalence have been identified and included in the planning process and the person can generally articulate their concerns • Expectation of relapse has been predicted with associated recovery plan responses and all participants agree on the extent of "failure" that can be accommodated in the community	
Current Level of Functioning		• The clinical team and the PNP provider have obtained current information (last 6 months) of strengths and weaknesses re functioning both on the campus and off the campus • The CVH team has a clear picture of the community setting to which the person is going (strengths and limitations)	
Risk Management		• The clinical team and the PNP provider have identified and assessed all risk issues and/or behaviors • The clinical team has clearly articulated the precipitating factors for risk issues and/or behaviors	
Contingency Plan		• The plan includes interventions that address the precipitating factors identified above • The plan clearly identifies the amount and kinds of relapse and/or failures that can be accommodated and/or tolerated in the community • The contingency plan utilizes temporary hospitalization, as needed, to interrupt relapsing or other risky behaviors. The hospital and/or Mobile Crisis Team identified has participated in the planning process • The contingency plan has been completed and agreed to by all	

☐Entitlements ☐ Medical Issues ☐ CRMHC Intake Completed ☐ PNP Intake Completed

☐ Other: _____