Revised: 11092022

LCDAC

Client Discharge Form

All fields are to be completed

Provider Name: _____

DDAP License #: _____

LCDAC Client #: _____

First Name: _____ **Last Name:** _____

Admit Date: _____ **Discharge Date:** _____

Last Treatment Date: _____ **Discharge Reason:** _____
(Please Select)

Living Arrangement: _____
(Please Select)

Employment Status: _____
(Please Select)

No. of Client Arrests 30 Days Prior to Discharge: _____

Frequency of Self-Help Program Attendance in the 30 Days Prior to Discharge: _____
(Please Select)

SUBSTANCE USE AT DISCHARGE

PRIMARY SUBSTANCE

Substance Used: _____ **Frequency:** _____
(Please Select) (Please Select)

SECONDARY SUBSTANCE

Substance Used: _____ **Frequency:** _____
(Please Select) (Please Select)

TERTIARY SUBSTANCE

Substance Used: _____ **Frequency:** _____
(Please Select) (Please Select)