

**Attachment 1**

**OFFICE OF MENTAL RETARDATION AND OFFICE OF MENTAL HEALTH AND  
SUBSTANCE ABUSE SERVICES IDENTIFICATION AND TREATMENT OF PERSONS WITH  
A DUAL DIAGNOSIS IN STATE MENTAL HEALTH HOSPITALS  
AND PROCEDURES FOR DISCHARGE PLANNING**

**Name(s) of Reviewers:**

\_\_\_\_\_

Date(s) of Review: \_\_\_\_\_

Name(s)/Title(s) of Hospital Staff providing information: \_\_\_\_\_

**INDIVIDUAL'S INFORMATION:**

1) Name: \_\_\_\_\_ 2) Date of Birth: \_\_\_\_\_

3) State Hospital/Ward: \_\_\_\_\_ 4) Hospital Case #: \_\_\_\_\_

5) Restrictions: \_\_\_\_\_

6) County of Origin/Responsibility: \_\_\_\_\_ 7) County Case#: \_\_\_\_\_

8) Hospital Commitment Type: \_\_\_\_\_

9) I.Q. Scores and Dates: \_\_\_\_\_

10) Evidence of Mental Retardation Prior to Age 18. Specify: \_\_\_\_\_

\_\_\_\_\_

11) Date(s) of, Diagnoses at time of, and Reason(s) for State Hospital Admission(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12) Current Diagnoses (all Axes):

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

13) Reason(s) for Continues Hospital Stay:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14) Current Medications, Dosages and Reason(s) for Each:

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15) Current Treatment Team Goals and Progress:

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16) Current Adaptive Skills:

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17) Current Work/Employment Interests/Potentials:

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18) Additional/Significant Information:

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19) Community Placement:

Read for Discharge: NOW \_\_\_\_ AT A LATER DATE \_\_\_\_

A) If NOW, list recommended supports:

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B) IF AT A LATER DATE, provide brief explanation for decision(s), and supports the team believes need to be in place to assist the person in discharge readiness:

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