



**PROBLEM GAMBLING**  
**OUTPATIENT TREATMENT AND CASE MANAGEMENT**  
**Discharge Plan and Summary**

Client ID: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Admission Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

Reason for Discharge:      **Successful-Satisfactory completion of goals (complete entire form with client)**

Complete only Section 1 for the following discharge reasons

**Client's health prohibits further attendance in treatment services**

**Discharged due to non-compliance with program rules**

**Client Relocated**

**Client no longer needs DDAP funding (still receiving services)**

**No contact with provider within 60 days**

**Client refuses further problem gambling services**

**Client arrested/incarcerated**

**Client deceased**

**SECTION 1    SUMMARY OF SERVICE AT DISCHARGE**

Describe summary of provided services, case management needs, issues, concerns, prognosis and recommendations.

Counselor/Case Manager Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SECTION 2 PROVIDER CONTACT INFORMATION**

In the event you need to reach out to us at any time.

Primary Counselor/Case Manager: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
\_\_\_\_\_

**SECTION 3 CONTINUING CARE PROVIDERS**

Below are providers you have a future appointment with following discharge from Gambling Services or will continue to receive services from (i.e. Financial Counseling, Primary Care Physician, Probation/Parole, Court date, Mental Health, Substance Use Treatment, Community Action, Food Bank)

Appointment Date & Time: \_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**SECTION 4 SUPPORT SYSTEM**

When I or my affected family member feels like gambling, I will contact my support system:

First Contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

Second Contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

It is recommended you become involved with the following services upon discharge (i.e. GA meetings, Gam-Anon, NA/AA meetings, other support groups). *Provide a list of meetings to client at discharge.* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 5 HIGH RISK SITUATIONS AND ACTION PLANS**

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

Situation: \_\_\_\_\_

Coping skills to promote recovery:

- 1.
- 2.
- 3.

**SECTION 6 CONTINUING CARE GOALS**

I will continue to work on the following goals after discharge (i.e. continue to pay off credit card debt, create a monthly budget, manage emotions or behaviors related to gambling):

Goal: \_\_\_\_\_

Goal: \_\_\_\_\_

Goal: \_\_\_\_\_

Goal: \_\_\_\_\_

Goal: \_\_\_\_\_

**SECTION 7 CLIENT SELF ASSESSMENT**

Please rate your well-being upon discharge on a scale of 1-10, 10 being the highest: \_\_\_\_\_

I understand that I can re-enter Gambling Outpatient Treatment and/or Gambling Case Management Services by contacting 1-800-GAMBLER or the provider(s) I have already worked with.

I participated in creating this plan and recognize the importance of following it.

The 988 Suicide and Crisis Lifeline was explained to me. I understand that it is free and I can call, text, or chat and my conversation is confidential. I recognize the importance of talking with someone and that 988 can connect me to my local services.

**SECTION 8 SIGNATURES REQUIRED ON THIS FORM**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor/Case Manager Signature

\_\_\_\_\_  
Date

Accepted a copy

Refused a copy