Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DISCHARGE FROM MENTAL HEALTH SERVICES

CONSULTANT CONTACT INFORMATION

Surname: ______________________ Forenames: ______________________

Address: ______________________ Phone No.: ______________________

Fax No.: ______________________

Email Address: ______________________

PERSON'S CONTACT INFORMATION

Surname: ______________________ Forenames: ______________________

Address: ______________________ Date of Birth: ______________________

PPS Number: ______________________

Phone No.: ______________________

PRESENTING COMPLAINT (S)

DIAGNOSIS (ICD 10)

PROGRESS OF TREATMENT TO DATE

CURRENT MEDICATIONS

FOLLOW UP APPOINTMENT/CARE PLAN

NAME AND CONTACT NUMBER OF KEY WORKER

OTHER INFORMATION

Housing/Social Needs: ______________________

Voluntary Agency: ______________________

Additional Support Needed: ______________________