

THE CHILDREN'S CENTER

THERAPEUTIC PRESCHOOL DISCHARGE REPORT

Child: _____ Date of Admit: _____
DOB: _____ Date of Discharge: _____
Age: _____ Therapeutic Preschool Specialist: _____
Co-Therapeutic Preschool Specialist: _____
Supervisor: _____

Referral Source & Reason:

Reason for Discharge:

Progress Toward Initial Referral Concerns:

Additional Services Provided: (please check)

Speech ___ Coll. Therapy ___ Medication Management ___ Individual Therapy ___

Group Treatment Summary:

Group Readiness:

Relationship with Adults/Peers:

Behavioral Control:

Emotional Regulation:

Communication:

Summary of Child's Functioning in Family:

Summary of Speech/Language Services:

Summary of Individual Therapy:

Summary of Medication Management:

Discharge Diagnosis:

DSM IV Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Discharge Plan:

Signature/Title