Therapy Discharge Summary

One page record of the whole episode of care

1. Client and episode of care

Client name or ID

Date of birth

Clinician and credentials

Intake date

First session

Last session

Discharge date

Sessions attended

Missed / cancelled

Frequency

Service type: ☐ Individual ☐ Couples or family ☐ Group ☐ In person ☐ Telehealth video

2. Clinical summary

Reason for referral and presenting problem (referred by, concerns at intake, client's words)

Diagnosis at intake (code)

Diagnosis at discharge (code, change and why)

Services provided (approach, measures with intake and discharge scores, coordination of care)

Progress on treatment goals (plan wording, status, evidence)

Goal 1 ☐ Met ☐ Partly met ☐ Not met

Evidence

Goal 2 ☐ Met ☐ Partly met ☐ Not met

Evidence

Goal 3 ☐ Met ☐ Partly met ☐ Not met

Evidence

3. Discharge, risk and aftercare

Reason for discharge: ☐ Goals met ☐ Mutual agreement ☐ Client chose to end ☐ Stopped attending ☐ Transfer ☐ Referral ☐ Moved or insurance ☐ Other

Status at discharge (symptoms vs intake, functioning, strengths and supports)

Risk at last contact: ☐ Assessed: low ☐ Moderate ☐ High ☐ Not assessed (say why) ☐ Safety plan reviewed ☐ No safety plan indicated ☐ Crisis resources given (988, 911)

Risk details and medications if known (name, prescriber, client reported?)

Aftercare recommendations (skills, follow up, when to return)

Referrals (provider or service, release signed?, connected?)

Prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Poor

Because

Clinician signature and credentials

Date signed

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Therapy Discharge Summary

One page record of the whole episode of care

FILLED EXAMPLE · fictional client and clinician, for illustration only

1. Client and episode of care

Client name or ID: J.T. (fictional example)

Date of birth: 04/12/1990

Clinician and credentials: M. Reyes, LMHC (fictional)

Intake date: 6/3/2026

First session: 6/10/2026

Last session: 10/28/2026

Discharge date: 10/28/2026

Sessions attended: 16

Missed / cancelled: 1 cancelled, 0 no shows

Frequency: Weekly x12, then every other week x3

Service type: [x] Individual [ ] Couples or family [ ] Group [x] In person [x] Telehealth video

2. Clinical summary

Reason for referral and presenting problem (referred by, concerns at intake, client's words)

Self referred on PCP's advice after 2 ER visits for chest pain, normal cardiac workups. "I can't get through a workday without a panic attack." 4 to 6 attacks a week; avoids highway driving and crowded stores; 3 sick days last month.

Diagnosis at intake (code): Panic disorder (F41.0)

Diagnosis at discharge (code, change and why): Panic disorder, retained; no attacks in last 6 weeks

Services provided (approach, measures with intake and discharge scores, coordination of care)

CBT for panic: psychoeducation, interoceptive exposure, cognitive restructuring, graded in vivo exposure, relapse prevention plan. PDSS 17 at intake, 9 at session 8, 3 at session 15. ROI signed 6/3; summaries sent to PCP 7/1 and 10/30.

Progress on treatment goals (plan wording, status, evidence)

Goal 1: 1.1 Panic attacks 1 or fewer a week for 4 consecutive weeks — [x] Met [ ] Partly met [ ] Not met

Evidence: 0 full attacks in weeks 11 to 16 (panic diary); 2 limited symptom episodes managed with skills; PDSS 17 to 3.

Goal 2: 2.1 Highway alone 20+ min, 2x a week; 2.2 crowded store 30 min — [ ] Met [x] Partly met [ ] Not met

Evidence: 2.1 met: highway commute alone 2 to 4x a week since week 10. 2.2 partly: still leaves Saturday trips early about half the time.

Goal 3: 3.1 No panic related sick days for 8 weeks — [x] Met [ ] Partly met [ ] Not met

Evidence: No sick days since week 4 (client report). Working full time.

3. Discharge, risk and aftercare

Reason for discharge: [x] Goals met [x] Mutual agreement [ ] Client chose to end [ ] Stopped attending [ ] Transfer [ ] Referral [ ] Moved or insurance [ ] Other

Status at discharge (symptoms vs intake, functioning, strengths and supports)

Mood "good, a bit nervous about doing this on my own"; affect bright. Mild anticipatory anxiety before Saturday shopping only. Working full time; sleeping 7 hours most nights. Strengths: motivated, consistent homework, supportive partner.

Risk at last contact: [x] Assessed: low [ ] Moderate [ ] High [ ] Not assessed (say why) [ ] Safety plan reviewed [x] No safety plan indicated [x] Crisis resources given (988, 911)

Risk details and medications if known (name, prescriber, client reported?)

Final session, practice screening questions: denies SI, intent, plan, self harm and HI; no firearms; alcohol 1 to 2 drinks a week. Sertraline 50 mg daily, prescribed by PCP since 5/2026 (client reported), unchanged; any taper to be planned with PCP.

Aftercare recommendations (skills, follow up, when to return)

Interoceptive practice 2x a week for 2 months; Saturday store exposure +5 min weekly; review relapse plan monthly. Return if panic attacks more than 1x a week for 2 weeks, driving avoidance returns, or before any medication taper.

Referrals (provider or service, release signed?, connected?)

PCP for medication follow up (ROI on file; summary sent 10/30). List of CBT therapists given in case of move. 3 month booster offered.

Prognosis: [x] Good [ ] Fair [ ] Guarded [ ] Poor

Because: full goal attainment, consistent homework, good insight, supportive partner; risks: job change, stopping meds.

Clinician signature and credentials: M. Reyes, LMHC (fictional)

Date signed: 10/30/2026

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Discharge Summary Checklist

Twelve checks before you sign, and how to close out a client who stopped attending

Before you sign

- [ ] 1. Intake, first session, last session and discharge dates are recorded and match the session log.
- [ ] 2. Sessions attended and missed are counted from the record, not from memory.
- [ ] 3. Reason for referral states who referred the client and why, in their words if recorded.
- [ ] 4. Diagnosis at intake and at discharge are both listed, with any change explained.
- [ ] 5. Services provided name the approach, measures with scores, and coordination of care.
- [ ] 6. Every goal from the treatment plan is accounted for: met, partly met, not met or dropped.
- [ ] 7. Each goal status has evidence: a score, a count, client report or observation.
- [ ] 8. Reason for discharge is factual and neutral, with no blame words or labels.
- [ ] 9. Risk at the last contact is recorded with the date, or the note says why it was not assessed.
- [ ] 10. Aftercare is concrete and says which signs should prompt a return to care.
- [ ] 11. Referrals name the service, the release status and whether the client connected.
- [ ] 12. Prognosis has reasons; signed with credentials and dated (addendum for later changes).

Closing out a client who stopped attending

1. **Check risk first.**
   Reread the last notes. If risk was present, reach out promptly and follow your risk procedures.
2. **Reach out and record it.**
   Call, secure message or letter, using the methods the client agreed to. Log date, method, result.
3. **Consider a closing letter.**
   Warm, brief: file closes by a stated date unless they call; welcome back; 988 and other resources.
4. **Write what you know.**
   Last session date, last known risk with its date, goals at that point. "Not assessed" is honest.
5. **Leave the door open.**
   Say how the client can return and what you offered. Keep a copy of any letter in the chart.

Records reminder (check your state and board)

HIPAA does not set a medical record retention period; HHS says state laws generally govern it.

HIPAA's 6 year rule (45 CFR 164.530(j)) covers HIPAA policies and documentation, not clinical charts.

APA guidance, absent other rules: 7 years after last service for adults, or 3 years after a minor

reaches the age of majority, whichever is later. Your state, board or contracts may require longer.

Clients can generally request their records; a discharge summary is part of the record.

Get a release where state law, Part 2 or your policy requires one before sending a summary.

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L&T

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Therapy Progress Notes and Intake Templates

Fillable PDF: includes a discharge summary page, plus intake, notes and safety plan pages (20 pages)

Holiday sale on Etsy until Dec 2: about $7.36, was $9

Get it on Etsy

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