

US PROBATION OFFICE – SOUTHERN DISTRICT OF GEORGIA  
MENTAL HEALTH DISCHARGE SUMMARY

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

Treatment Program: \_\_\_\_\_

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

DSM IV Diagnosis: \_\_\_\_\_

Reason for Termination: *(Check one)*

Successful Discharge

*Explain:*

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Unsuccessful Discharge

*Explain:*

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Interruption of Treatment

*Explain:*

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Vendor Comments: *(Use additional pages if needed)*

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Recommendations for community based aftercare:

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Counselor Signature

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Date