Social workers will complete a Psychosocial Assessment/Discharge Plan for all patients that remain at PHF beyond 72 hours. This document shall be present by the third day of the patient's hospitalization. If the necessary information for this report is not obtainable by the third day, the social worker may request time extensions in increments of three days for completion of this document by requesting this in writing, with reasons documented in the Social Services Section of the chart.

The Psychosocial Assessment/Discharge Plan will record the following information:

A. The patient's identifying characteristics
B. Reason for admission
C. Psychiatric and medical history
D. The patient's social history, including family background, living locations, childhood development, social relationships, education, employment and financial information, marital and children, forensic history, cultural factors and spirituality
E. Social evaluation
F. Discharge plan

If a Psychosocial Assessment/Discharge Plan has been previously dictated on a patient within the previous year before admission an updated report of the patient's current situation may be substituted and attached to the previously dictated report.

Social workers will also complete a daily note to capture therapeutic interventions, collateral contacts, and updates regarding patient treatment. In addition at least once weekly, as long as the patient remains in the facility, this social worker note must address all of the following information:

A. Patient's psychosocial, clinical, and legal status
B. Discharge/aftercare/placement plan
C. Obstacles to achieving the plan
D. Social worker's activities towards achieving plan and other relevant information

Social worker discharge note will specifically include confirmation that discharge information has been faxed/sent to post hospital care providers to insure continuity of care.