Mental Health Discharge Summary Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A mental health discharge summary closes an episode of care: why treatment started, the course and response, final diagnoses, condition and risk status at discharge, and the aftercare plan. Hospitals and community mental health centers must produce one under Medicare rules; outpatient therapists write one at termination as professional practice. Always record the episode dates: they bound the summary and let a reviewer match it to the chart.

Reason for treatment why care started
Do: give two or three sentences on the presenting problem, the diagnosis at intake, and any precipitating events.
Pitfall: restating the whole intake note; orient the reader and move on, the intake note holds the detail.

Course of treatment the arc, not the sessions
Do: cover modalities, frequency, attendance, response, and significant events: level-of-care changes, crises, medication changes.
Pitfall: a session-by-session replay; summarize the arc, the progress notes hold the sessions.

Final diagnoses reconciled with intake
Do: record the discharge diagnoses and state any change from intake rather than leaving it for the reader to discover.
Pitfall: an intake diagnosis carried forward unexamined when the course of treatment plainly revised it.

Condition at discharge measures make it credible
Do: describe clinical status at the final contact, with outcome measures at baseline and discharge where you have them.
Pitfall: writing "improved" with no score, example, or functional detail to support it.

Reason for discharge say what actually happened
Do: state it plainly: goals met, mutual decision, client-initiated, lost to contact after documented outreach, transfer, administrative.
Pitfall: euphemism; "completed treatment" written over a lost-to-contact ending misstates the record.

Medications at discharge one named prescriber
Do: list the final medications, changes made during the episode, and who manages each prescription going forward.
Pitfall: a list that changed during treatment with no reconciliation, so the next prescriber inherits a contradiction.

Risk status at discharge where the next reader looks first
Do: document the risk picture at the final contact and any safety plan completed or updated during the episode.
Pitfall: silence on risk in the closing document, in the window where post-discharge risk concentrates.

Aftercare plan names, dates, return criteria
Do: give referrals with names and contacts, appointments with timeframes, crisis resources provided, and what should bring the client back.
Pitfall: "follow up as needed"; name the provider, the interval, and the return criteria.

Pending items every item needs an owner
Do: list records to forward, outstanding results, open authorizations, and who owns each one.
Pitfall: unowned pending items; once the episode closes, they die quietly.

Before you sign

- [ ] Episode dates and level of care bound the summary
- [ ] Outcome measure at baseline and discharge recorded
- [ ] Reason for discharge stated plainly, no euphemism
- [ ] Risk status documented at the final contact
- [ ] Aftercare names a provider, timeframe, and return criteria
- [ ] Medications reconciled with a named prescriber
- [ ] Release signed for any copy sent outside the practice

Drafting with AI

Capture 30 seconds of bullets when you close the chart: episode dates, diagnosis arc, response, reason for discharge, risk status, aftercare.

"Draft a mental health discharge summary from this chart: outpatient CBT episode February to July, depression moving from moderate to partial remission, PHQ-9 16 to 5, planned termination, PCP continues sertraline, relapse-prevention plan complete: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

300–1,200 words	20–45 min by hand	End of an episode	Next provider · PCP · payer · client
typical length	clinical team estimate	when it is written	who reads it

Full guide and sample summary:
bastiongpt.com/template/discharge-summary

BastionGPT drafts the summary from your chart notes. Free 7-day trial.

Mental Health Discharge Summary Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | Program / level of care: | Episode (from / to):

Clinician / team / credentials: | Referral source: | Summary date:

Reason for treatment
Presenting problem, diagnosis at intake, precipitating events, baseline measure

Course of treatment
Modalities, frequency, attendance, response; level-of-care changes, crises, medication changes

Final diagnoses
Discharge diagnoses with codes; note any changes from intake

Condition at discharge
Status at final contact; outcome measures at baseline vs discharge; functioning

Reason for discharge
Goals met / mutual / client-initiated / lost to contact after documented outreach / transfer / administrative

Medications at discharge
Final list; changes during the episode; who manages each prescription going forward

Risk status at discharge
Risk picture at final contact; safety plan completed or updated; crisis resources provided

Aftercare plan
Referrals with names and contacts; appointments with timeframes; return criteria; who receives this summary

Pending items
Records to forward, outstanding results, open authorizations; the owner of each

Clinician signature / credentials: | Supervisor signature (if required): | Date signed: