Treatment Closure Check List

Counselor: _____ Date: _____

Client: _____

1. Discharge Summary.....	☐ Yes	☐ No	☐ N/A
2. Initial ODADAS/Behavior Module, IOP Only	☐ Yes	☐ No	☐ N/A
3. Closure ODADAS, IOP Only.....	☐ Yes	☐ No	☐ N/A
4. Progress Notes (Stapled).....	☐ Yes	☐ No	☐ N/A
5. Assessment.....	☐ Yes	☐ No	☐ N/A
6. Admission Criteria Level of Care.....	☐ Yes	☐ No	☐ N/A
7. Continued Stay Level of Care.....	☐ Yes	☐ No	☐ N/A
8. Discharge Level of Care.	☐ Yes	☐ No	☐ N/A
9. Relapse Prevention Plan	☐ Yes	☐ No	☐ N/A
10. Master Treatment Plan.....	☐ Yes	☐ No	☐ N/A
11. Assessment Screening Battery.....	☐ Yes	☐ No	☐ N/A
12. Consent Packet.....	☐ Yes	☐ No	☐ N/A

* If you mark “No” in any box, you must provide the reason in the Comment Section below *

Comments: