Connecticut Department of Children and Families

INTIMATE PARTNER VIOLENCE – FAMILY ASSESSMENT INTERVENTION RESPONSE DISCHARGE FORM

DCF-1102

9/18 (New)

Date of Discharge	Agency:

CARETAKER / ADULT #1			CARETAKER / ADULT #2		
LAST Name:	FIRST Name	M.	LAST Name:	FIRST Name	M.
Received Services?: ☐ Yes ☐ No			Received Services?: ☐ Yes ☐ No		
If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No			If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No		
List Services Received:			List Services Received:		
If no, what prevented full dose of recommended treatment to occur:			If no, what prevented full dose of recommended treatment to occur:		
Admission Date:	Discharge Date:		Admission Date:	Discharge Date:	
Clinician Name:	Navigator Name:		Clinician Name:	Navigator Name:	

CHILD #1			CHILD #2		
LAST Name:	FIRST Name	M.	LAST Name:	FIRST Name	M.
Received Services?: ☐ Yes ☐ No			Received Services?: ☐ Yes ☐ No		
If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No			If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No		
List Services Received:			List Services Received:		
If no, what prevented full dose of recommended treatment to occur:			If no, what prevented full dose of recommended treatment to occur:		
Admission Date:	Discharge Date:		Admission Date:	Discharge Date:	
Clinician Name:	Navigator Name:		Clinician Name:	Navigator Name:	

CHILD #3			CHILD #4		
LAST Name:	FIRST Name	M.	LAST Name:	FIRST Name	M.
Received Services?: ☐ Yes ☐ No			Received Services?: ☐ Yes ☐ No		
If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No			If yes, did caretaker/adult receive the full dose of recommended treatment: ☐ Yes ☐ No		
List Services Received:			List Services Received:		
If no, what prevented full dose of recommended treatment to occur:			If no, what prevented full dose of recommended treatment to occur:		
Admission Date:	Discharge Date:		Admission Date:	Discharge Date:	
Clinician Name:	Navigator Name:		Clinician Name:	Navigator Name:	

OUTCOME EXPECTATIONS
Was family connected to resources and services in the community to address identified needs? ☐ Yes ☐ No
Did family discharged meet 70% of treatment goals? ☐ Yes ☐ No
If family received Fathers for Change, did family discharged meet 70% of treatment goals? ☐ Yes ☐ No
Goals Met:

Goals Unmet:
Unmet Safety Concerns
Present functioning of family:
Reason for Closing:

Recommendations:		
Name of Clinician	Signature of Clinician	Date
Name of Family Navigator	Signature of Family Navigator	Date
Name of Supervisor	Signature of Supervisor	Date