* 4 0 2 0 5 *

ACT Health

Name:

Date of Birth:

URN:

Or affix patient label

Transition/Exit Report
IMPACT Program

Date of Meeting: _____ **Reason for Meeting:** ☐ **Transition** ☐ **Exit from Program**

Attendees: ☐ Information distributed to all agencies involved

Agency	Representative	Service Provided	Contact Frequency

Apologies:

Agency	Representative	Service Provided	Contact Frequency

If meeting was not held, please state the reason:

Reason for Transition/Exit: ☐ Client goals met ☐ Client moving from jurisdiction ☐ Client no longer meets eligibility criteria
☐ Client withdrawal ☐ Other (specify)

Client:	**Date of Birth:**	**Date of Meeting:**
Summary of Agency Involvement:		
Achievements:		
Transition/Exit Plan:		
Name of Person completing plan: _____ **Signature:** _____ **Agency:** _____ **Date:** _____		
Client/Consumer agreement to plan: _____ **Signature:** _____ **Notification to:** ☐ **Agencies** ☐ **IMPACT Coordination Team**		