Discharge From After-Care

This section must be completed when the patient is discharged from after-care

Once this section is completed, copies of this form must be sent to everyone involved in the patient's after-care.

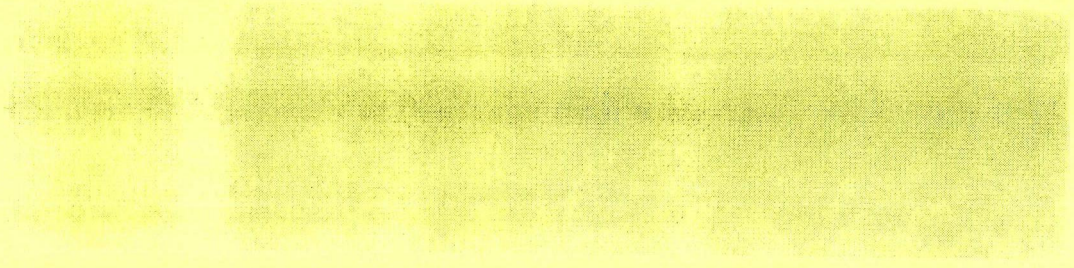
Name:

Address:

Contact Number:

Certificate of Agreement to Discharge from After-Care

The patient was discharged from after-care on _____
because *(give reasons)*



Signed **Print Name**

On behalf of the Health Authority **Title**

Signed **Print Name**

On behalf of the Local Authority **Title**

A copy of this form was sent to: *Date Sent*