



PT

## DISCHARGE SUMMARY

Type of Visits:  PT  OT  ST

Patients Name: \_\_\_\_\_

Doctors Name: \_\_\_\_\_

HHA: \_\_\_\_\_

Admit Date: \_\_\_\_\_ D/C Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Status of Problems identified throughout course of care (Specific Care Given, Intervention, Progression, regression, unmet goals)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Problems identified upon admission:

\_\_\_\_\_  
\_\_\_\_\_

Reason for D/C:  Goals Met  Admitted to facility  Moved  
 Patient/Physician Request  Deceased

Condition on Discharge:  Independent  Needs Assistance

Patient/Caregiver retention of information

Good  Fair  Poor

Discharge Instructions Given:  Yes  No

Counseled to continue to medical follow up with their physician

Counseled to call agency for further home care needs

5 Day Discharge notice given

Copy to physician Date: \_\_\_\_\_

\_\_\_\_\_  
Therapists Signature

\_\_\_\_\_  
Date