



ST

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