

Patient Name:
 DOB:
 Start of Care Date:
 Discharge Date:

THERAPY DISCHARGE SUMMARY



- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology

Facility:

Medical Dx:

Treatment Dx:

Summary of Treatment Provided:

Goals / Objectives:	Admit Status	Discharge Status	Goals Met
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Assessment:

Reason for discharge:

Prognosis for maintaining current status:

Follow-up Recommendations:

Therapist Signature: _____ Date: _____