PRIMA HOME HEALTH, LLC

Therapy Discharge Summary

Patient Name: _____

Agency Name: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Start of Care Date: _____ Initial Evaluation Date: _____ Discharge Date: _____

DISCHARGE REASON

☐ Goals Met ☐ Physician Ordered ☐ Patient Request ☐ Patient Expired ☐ Patient Moved From Service Area
☐ Other (specify): _____

DISCHARGE DESTINATION

☐ Remains at Home ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Acute Hospital
☐ Other (specify): _____

INTERVENTIONS PROVIDED THROUGHOUT THIS EPISODE OF CARE

OBJECTIVE MEASURES	STATUS AT INITIAL EVALUATION	STATUS AT DISCHARGE

Were all therapy plan of care goals achieved? ☐ Yes ☐ No (Provide explanation of unmet goals below)

If no, explain: _____

DISCHARGE RECOMMENDATIONS/INSTRUCTIONS (Home Program, Equipment Needs, Safety Measures)

PATIENT/CAREGIVER REPSONSE TO DISCHARGE INSTRUCTIONS

Discharge Coordinated With: ☐ Physician ☐ Agency ☐ Patient/Caregiver

Therapist Signature/Credentials: _____ **Date:** _____

Therapist Name (printed): _____