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THErapy DISCHARGE SUMMARY

PATIENT LAST NAME _____ FIRST NAME _____ PATIENT # _____

TYPE OF DISCHARGE: COMPLETE PARTIAL - STILL RECEIVING SERVICES OF: PT ST OT HHA SN

ADM DATE _____ DISCH DATE _____ DR _____

DIAGNOSIS (PRIMARY) _____ ADDRESS _____
CITY, ST _____ ZIP _____

VISITS RENDERED BY: _____ RN _____ HHA _____ PT _____ OT _____ ST _____ MSW _____

REASON FOR DISCHARGE: GOALS MET MOVED OUT OF AREA OTHER
 HOSPITALIZATION PATIENT EXPIRED
 SKILLED NURSING FACILITY CARE REFUSED
 TRANSFER TO ANOTHER AGENCY SKILLED CARE NO LONGER NEEDED

DISPOSITION SELF CARE NH ACLF FAMILY CARE OTHER

CONDITION IMPROVED STABLE UNSTABLE DECEASED REGRESSED

DEPENDENCY DEPENDENT INDEPENDENT REQUIRES SUPERVISION/ASSIST

EXERCISES PASSIVE ACTIVE ACTIVE ASSISTIVE RESISTIVE

PERFORMED WITH: R.U.E. R.L.E. L.U.E. L.L.E. TRUNK NECK

TRANSFER HOYER LIFT CRUTCHES WALKER

ACTIVITIES: W/C CANE QUAD CANE OTHER _____

GAIT TRAINING: N.W.B. P.W.B. F.W.B.

EVEN SURFACES STAIRS UNEVEN SURFACES

ASSISTANCE REQUIRED: MAXIMUM MINIMUM MODERATE GUARDING OTHER _____

DISTANCE AMBULATED: 20 ft. 40 ft. 60 ft. 80 ft. 100 ft. 120 ft.

INSTRUCTED ON HOME PROGRAM: PATIENT SIGNIFICANT OTHER FAMILY

NARRATIVE: _____

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

- ____ PATIENT HAS ACHIEVED ANTICIPATED GOALS
- ____ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
- ____ ABSENCE OF PAIN
- ____ FREE OF CONTRACTURES
- ____ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
- ____ DEMONSTRATES RANGE OF MOTION EXERCISES
- ____ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
- ____ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
- ____ AMBULATES SAFELY WITH ASSISTIVE DEVICE
- ____ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

- ____ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
- ____ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
- ____ HEALED INCISION
- ____ DEMONSTRATES STUMP WRAPPING AND HYGIENE
- ____ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
- ____ DESCRIBES PHANTOM LIMB SENSATION
- ____ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Speech Therapy

- ____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- ____ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
- ____ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

Occupational Therapy

- ____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- ____ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
- ____ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
- ____ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: GOOD FAIR POOR

THERAPY GOALS MET: YES NO IF NO, EXPLAIN _____

PATIENT/S.O. GOALS MET: YES NO IF NO, EXPLAIN _____

COMMENTS: _____

PATIENTS/SOs INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE _____ DATE _____
White: Medical Records Yellow: Physician