TNS TOTAL NURSING SERVICES INC
5951 NW 173 Dr. Suite 11
Miami, FL 33015
305-362-1211

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

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

____ 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

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/So. 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