Client Name: ________________________________________________________________

Start of Care Date: __________________________ Last Date of Service: __________________________

Discharge Date: ____________________________ Diagnosis: _________________________________

Physician Name: ____________________________ Telephone Number: __________________________

Description of Care Provided:

Instructions Given to Patient:

Were Goals of Service met? If not, why?

Patient’s condition at time of Transfer/Discharge:

Discharge assessment completed Yes __________ No __________

If no why? ________________________________________________________________

Check all that apply:
☐ Patient agreeable with discharge
☐ Physician notified of discharge
☐ Patient referred to outpatient services
☐ Patient to follow up with physician
☐ Other: ________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Signature ____________________________ Date ____________________________

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