Client Name: ________________________________________________________________

Start of Care Date: ___________________________ Last Date of Service: ___________________________

Discharge Date: ___________________________ Diagnosis ___________________________

Reason for Providing Services:

Services Provided:

Were Goals of Service met? If not, why?

Patient’s condition at time of Transfer/Discharge:

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 ___________________________