



**Transfer/Discharge  
Summary**

Client Name: \_\_\_\_\_

Start of Care Date: \_\_\_\_\_ Last Date of Service: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

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