PT / OT / ST / Discharge Summary Rev3

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Pt Name _____ **SOC**_____**MR#**_____

Discharge Date _____ ☐ With visit Time in: _____ Time out_____
Discharge/Transfer/death date If not with visit Last visit date_____

Disciplines remaining in care: (RN-indicate therapist name and anticipated/actual discharge date) ☐ NONE if none just do D/C OASIS

☐ Case Manager _____ ☐ PT_____ ☐ OT _____
☐ST_____ ☐CNA_____ ☐MSW_____

Notified: ☐ Case Manager, ☐ Patient, ☐ Caregiver/Family ☐ MD _____(order for early discharge)

D/C Reason

☐Pt centered Goals achieved. ☐Pt/family request ☐Noncompliance with POC
☐Pt refused further care ☐MD request ☐ Geographic relocation
☐Is not homebound (give reason and complete D/C OASIS) ☐Other_____
Discharge to ☐Self ☐Hospital ☐Outpatient ☐ SNF ☐Hospice ☐ _____
Disposition at discharge: ☐Improved ☐No change ☐ Regressed

Reason For Admission:

Summary of care (including progress towards goals to date)

Discharge Instructions/Interventions provided with this visit :

BP (resting) R:_____ / _____ L: _____ / _____ Pulse (rested)_____Pulse (After activity)_____

Reviewed: ☐Home Safety ☐Fall Safety ☐When to contact MD ☐Next appointment with MD ☐Standard precautions ☐_____
Written instructions/Home exercise program given to Patient/Caregiver ☐Yes ☐No, explain_____

Therapist Signature **Date**

Patient Signature **Date**