Discharge Summary (PT)

Clinician:

Patient Name (Last Name, First Name) & MRN:	Mileage:	Gender: ☐ M ☐ F	Agency Name/Branch:

Date: / /	Time In:	Time Out:	DOB: / /

Reason For Discharge

O Goals met / max potential reached
O No longer homebound
O Refused assistance / care
O Noncompliant
O Per patient / family request
O Hospitalized
O Prolonged on-hold status
O Hospice
O Nursing home admission
O Move from service area
O Deceased

Other:

Physicians

Primary Physician:

Secondary Physician:

Condition at Discharge

Current Status:

☐ Independent ☐ Dependent ☐ Needs Assistance ☐ Needs Supervision ☐ Deceased

Physician and Psychological Status

Care Summary *(care given, progress, regress including therapies):*

Goals Summary / Outcomes

☐ Goals Met
☐ Lack of progress
☐ Improved Independence
☐ Condition Improved
☐ Stabilized
☐ Improved functional status
☐ Max potential reached
☐ Deterioration of functional status
☐ Improved knowledge of self care management

Other:

Goals Not Met:

Discharge Summary (PT)

Patient Name (Last Name, First Name) & MRN:	Date:

Discharge Information

Discharge instructions provided?	O	Yes	O	No	☐	Patient	☐	Caregiver
Medically necessary / appropriate follow-up advised?	O	Yes	O	No	☐	Patient	☐	Caregiver
Understanding of need for medical follow-up verbalized?	O	Yes	O	No	☐	Patient	☐	Caregiver
Medications reviewed at discharge visit?	O	Yes	O	No	☐	Patient	☐	Caregiver
Able to comprehend discharge instructions?	O	Yes	O	No	☐	Patient	☐	Caregiver
Instructed to call agency of choice for future home care needs?	O	Yes	O	No	☐	Patient	☐	Caregiver
Informed of discharge prior to discharge date, per agency policy & timeline?	O	Yes	O	No	☐	Patient	☐	Caregiver

Information Provided for continuing Needs / Specific Discharge Instructions

To: ☐ Patient ☐ Caregiver ☐ Facility Staff ☐ Other (specify below)

Information Provided:

Resources Ongoing:

☐ Nursing home ☐ State program ☐ Meals on wheels ☐ Community volunteer organization ☐ Private duty care

Other:

Living Arrangements at Discharge:

O Home O Caregiver's home O Nursing home O Assisted living / foster care

Other:

Care Coordination

☐ Discharge form home health services ☐ Scheduler notified ☐ Physician notified of discharge summary availability

☐ All services notified and discontinued ☐ Private services offered ☐ Report given to assuming agency with Advance Directive status

☐ Order and summary completed ☐ Physician notified of discharge prior to discharge date, per agency policy & timeline

Other:

Signature & Title

Date: / /