



Therapy Station

Progressing towards Independence

Discharge Summary

Patient Name: _____ **DOB:** __/__/____

Date of Discharge: __/__/____

Therapy Being Discharged From:(Please Circle)

Speech Therapy

Occupational Therapy

Physical Therapy

Reason For Discharge:(Please Circle)

Achieved all Goal / Moving / Changing Therapy Company /

Noncompliance / No Show / No Longer Eligible

Other: _____

Recommendations: (Please Circle)

Continue w/services / Home Program

Comments:

Therapist Signature

Date