

Transfer/Discharge Summary

Client Name: _____

Start of Care Date: _____ Last Date of Service: _____

Discharge Date: _____ Diagnosis: _____

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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: _____