WellsBrooke
CERTIFIED HOME HEALTH CARE

☐ MSW ☐ PT
☐ OT ☐ SLP

Therapy/Social Work Discharge Summary

Patient Name:_____ **MR#:**_____ **SOC:**_____

D/C Date:_____ ☐ No Visit ☐ With Home Visit - Time In:_____ Time Out:_____

D/C Initiated by: ☐ MD ☐ Home Health Agency ☐ Patient/Family Date of Last Visit:_____

Diagnosis(es):_____

Discharged to: ☐ Self ☐ Family ☐ Hospital ☐ ECF ☐ Other:_____

Mental Status: ☐ Alert/Orientated ☐ Confused/Disoriented ☐ Specify:_____

Emotional Status: ☐ Coping ☐ Not Coping ☐ Specify:_____

Discharge Assessment:

_____

_____

_____

_____

Discharge Intervention/Instructions/Analysis of Responses:

_____

_____

_____

Reason for Discharge:

☐ No Further Care Needed
☐ Admitted to Hospital
☐ Admitted to SN/IC Facility
☐ Family/Friends Assume Responsibility
☐ Death Date:_____
☐ Patient Refused Services
☐ Transferred to Another HHA
☐ Transferred to Outpatient Rehab.
☐ Physician Request
☐ Not Homebound
☐ Lack of Progress
☐ Required D/C Prior to Hospice Benefit
☐ Transferred to Attendant/Private Care
☐ Patient Moved Out of Area
☐ Other:_____

Summary of Care Including Goals Met:

_____

_____

_____

_____

Goals Not Met:

_____

_____

☐ Pt./Family aware of discharge ☐ Pt./Family instructed on follow-up care ☐ Physician notified-date:_____

Signature and Title:_____ **Date**: _____

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White Copy - Office Yellow Copy - Patient