

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Facility: [Insert Facility Name]

Dear [Patient Name/Family Member Name],

The following document outlines the expected clinical and functional goals for your inpatient rehabilitation stay. These goals are designed to facilitate a safe transition to your next level of care.

1. Functional Mobility Goals

- **Bed Mobility:** Patient will be able to roll and sit up in bed with [level of assistance].
- **Transfers:** Patient will safely transfer from bed to chair/wheelchair with [level of assistance].
- **Ambulation:** Patient will walk [distance] feet using a [type of assistive device] with [level of assistance].

2. Activities of Daily Living (ADLs)

- **Self-Care:** Patient will perform upper and lower body dressing with [level of assistance].
- **Hygiene:** Patient will manage grooming and bathing tasks independently or with minimal assistance.
- **Feeding:** Patient will independently manage meal setup and self-feeding.

3. Clinical and Safety Goals

- **Pain Management:** Patient will report pain levels at or below [number]/10 to participate in therapy.
- **Medication Management:** Patient will demonstrate understanding of new medication schedules and side effects.
- **Safety Awareness:** Patient will consistently demonstrate safety precautions to prevent falls.

4. Discharge Criteria

Success in this program is defined by the patient's ability to [insert specific discharge requirement, e.g., navigate 3 steps or manage equipment]. Our target discharge date is [Insert Estimated Date], pending the achievement of these milestones.

Sincerely,

[Physician/Therapist Name]
[Title/Department]
[Contact Information]