

REHABILITATION CENTER DISCHARGE SUMMARY

Date: [Date of Discharge]

PATIENT INFORMATION

Patient Name: [Full Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

Admission Date: [Date]

Discharge Date: [Date]

ADMITTING DIAGNOSIS:

[List primary reason for admission]

TREATMENT SUMMARY:

During the stay, the patient participated in [Physical/Occupational/Speech] therapy. The patient has achieved the following milestones: [List key progress or goals met].

DISCHARGE STATUS:

The patient is being discharged to: [Home/Assisted Living/Skilled Nursing Facility].

Condition at discharge: [Stable/Improved/Other].

MEDICATIONS:

The following medications are prescribed upon discharge:

1. [Medication Name] - [Dosage] - [Frequency]

2. [Medication Name] - [Dosage] - [Frequency]

FOLLOW-UP CARE & INSTRUCTIONS:

- Scheduled follow-up appointment: [Date/Time] with [Doctor Name].

- Home exercises: [Brief description].

- Restrictions: [List any activity or dietary restrictions].

EMERGENCY CONTACT:

If the patient experiences [List symptoms like fever or sudden pain], please contact [Phone Number] or visit the nearest emergency room.

AUTHORIZED BY:

[Physician/Program Director Name]

[Facility Name]