

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Admission: [Admission Date]

Date of Discharge: [Discharge Date]

To: [Primary Care Physician Name]

Facility/Clinic: [Clinic Name]

Subject: Discharge Summary - Geriatric Fall Prevention Rehabilitation

Dear Dr. [Physician Last Name],

The above-named patient has been discharged from our Fall Prevention Rehabilitation program. The goal of treatment was to improve postural stability, increase lower extremity strength, and mitigate home environment risks following a [recent fall / high-risk assessment].

Clinical Outcomes:

- **Mobility Status:** [e.g., Independent with rolling walker / Supervision required]
- **Balance Assessment:** [e.g., Berg Balance Scale score improved from X to Y]
- **Strength:** [e.g., Improved 5-Time Sit-to-Stand from X seconds to Y seconds]

Home Safety and Equipment:

- [Item 1: e.g., Grab bars installed in bathroom]
- [Item 2: e.g., Removal of area rugs completed]
- **Assistive Device Prescribed:** [e.g., Front-wheeled walker]

Medication Changes:

[List any medications adjusted to reduce dizziness/orthostatic hypotension, or state "No changes made"].

Discharge Recommendations:

- Continue Home Exercise Program (HEP) 3 times weekly.
- Follow up with Ophthalmology for vision screening.
- Follow up with Primary Care in [Number] weeks for medication review.

Please contact our department at [Phone Number] if you require further clinical details.

Sincerely,

[Your Name/Signature]
[Your Title/Credentials]
[Facility Name]