

**Date:** [Date]

**To:** [Adjuster Name]

**Insurance Carrier:** [Insurance Company Name]

**Fax/Email:** [Contact Information]

**RE: Workers' Compensation Discharge Summary**

**Patient Name:** [Patient Full Name]

**Claim Number:** [Claim #]

**Date of Injury:** [DOI]

**Date of Discharge:** [Last Date of Service]

To Whom It May Concern,

Please be advised that the above-referenced patient has been formally discharged from chiropractic care at this clinic for the work-related injury sustained on [Date of Injury].

**Reason for Discharge:**

- Patient has reached Maximum Medical Improvement (MMI).
- Goals of the treatment plan have been successfully met.
- Patient is non-compliant with the treatment schedule.
- Patient has self-discharged/failed to return for follow-up.

**Clinical Status at Discharge:**

The patient has completed [Number] sessions. At the time of discharge, the patient reports a pain level of [0-10] compared to [0-10] at the start of treatment. Objective findings indicate [Summary of improvement in range of motion or functional capacity].

**Work Status:**

The patient is released to:

Full Duty with no restrictions effective [Date].

Modified Duty with the following permanent restrictions: [List Restrictions].

**Final Recommendations:**

The patient has been instructed on a home exercise program to maintain functional gains. No further chiropractic intervention is requested at this time.

Sincerely,

[Doctor Name, DC]

[Clinic Name]

[Phone Number]