

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert DOB]

**Patient ID:** [Insert ID Number]

**Date of Admission:** [Insert Date]

**Date of Discharge:** [Insert Date]

**To:** [Referring Physician/GP Name]

## **Subject: Occupational Therapy Discharge Summary**

**Diagnosis:** [e.g., Post-Stroke, Traumatic Brain Injury, Multiple Sclerosis]

### **Reason for Referral:**

[Briefly describe functional limitations at start of therapy]

### **Summary of Interventions:**

During the course of treatment, the patient participated in:

- Upper limb rehabilitation and neuro-reeducation.
- Cognitive retraining (attention, memory, executive functioning).
- Activities of Daily Living (ADL) retraining.
- Visual-perceptual processing tasks.
- Home environment assessment and equipment prescription.

### **Outcomes and Functional Status:**

At the time of discharge, the patient's functional status is as follows:

- **Self-Care:** [e.g., Independent / Requires minimal assistance]
- **Mobility/Transfers:** [e.g., Safe with rolling walker]
- **Cognition:** [e.g., Improved safety awareness]
- **Upper Limb Function:** [e.g., Functional gross motor control achieved]

### **Discharge Disposition:**

The patient is being discharged from Occupational Therapy services due to: [e.g., Goals met / Plateau in progress / Transition to community care].

### **Recommendations and Follow-up:**

[e.g., Continue Home Exercise Program, Follow up with outpatient neurology in 3 months, Continued use of adaptive equipment].

Sincerely,

[Your Name, OT Reg.]

Occupational Therapist  
[Department/Facility Name]