[Date]

[Insurance Carrier Name]
[Claims Adjuster Name]
[Address]
[City, State, Zip Code]

RE: Workers Compensation Discharge Summary

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number: [Claim #]
Date of Injury: [DOI]
Employer: [Employer Name]

To Whom It May Concern,

Please be advised that the above-named patient has been formally discharged from [Type of Therapy, e.g., Physical Therapy] effective [Discharge Date].

Reason for Discharge:
[Select one: Goal Achievement / Maximum Medical Improvement / Non-compliance / Referral to Specialist]

Summary of Progress:
The patient completed [Number] sessions. At the start of treatment, the patient presented with [Initial Limitations]. Following the treatment plan, the patient has demonstrated [Current Functional Status/Improvements].

Final Functional Status:
[Detail current range of motion, strength, and ability to perform job-related tasks].

Work Status Recommendations:
[Select one: Return to full duty without restrictions / Return to modified duty with the following restrictions: [List Restrictions] / Unable to return to previous occupation.]

Follow-Up Plan:
The patient has been instructed in a Home Exercise Program (HEP). No further therapy sessions are scheduled at this time.

If you require any further documentation or clinical notes, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Printed Name and Title]
[Facility Name]