Date: [Date]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Referral Diagnosis: [Diagnosis/Surgical Procedure]
Date of Initial Evaluation: [Date]
Date of Discharge: [Date]

To: [Referring Physician Name]

Reason for Discharge:
[ ] Goals Met
[ ] Therapy Plateau
[ ] Patient Non-compliance/Missed Appointments
[ ] Transition to Home Health/Outpatient Rehab

Summary of Treatment:
Patient was seen for [Number] sessions of Occupational Therapy focusing on upper extremity rehabilitation, including: [Range of motion, strengthening, manual therapy, ADL training, splinting].

Clinical Outcome:

- **Range of Motion:** [Specify improvements or final measurements]
- **Strength:** [Specify MMT grades or grip strength]
- **Pain Level:** [Pre-treatment vs. Post-treatment]
- **Functional Status:** [Independent/Modified Independent/etc. in ADLs]

Home Exercise Program:
Patient has been provided with a final home exercise program and has demonstrated independent performance of all exercises.

Recommendations:
[Insert specific follow-up instructions or precautions here].

Sincerely,

[Therapist Signature]
[Therapist Name, Credentials]
[Facility Name]