CLEAR FORM

RecoverHealth
We bring health care home

DISCHARGE/TRANSFER SUMMARY REPORT

☐ TRANSFER SUMMARY ☐ DISCHARGE SUMMARY DISCIPLINE: ☐ OT ☐ PT ☐ SLP

CLIENT NAME	BRANCH	DISCHARGE DATE

Client is still receiving services of : ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSS Physician:_____
Diagnosis: _____Admission date: _____Final visit date:_____

REASON FOR DISCHARGE/TRANSFER
☐ Discipline Discharge ☐ Agency Discharge
☐ No Further Skilled Care Needed ☐ Refused Service ☐ Physician Request
☐ Moved Out of Area ☐ Lack of Progress ☐ Not Homebound
☐ Admitted To:_____ ☐ Client/Family Noncompliant and MD Concurs
☐ Expired (date:_____ ☐ Other:_____
Were Goals Achieved? ☐ Yes ☐ No (explain)

CLIENT INFORMATION – OASIS Functional Domains:
M1810 UB Dressing: ☐ 0-Unaided; ☐ 1-Set-up; ☐ 2-Assist of 1; ☐ 3-Dependent
M1820 LB Dressing: ☐ 0-Unaided; ☐ 1-Set-up; ☐ 2-Assist of 1; ☐ 3-Dependent
M1830 Bathing: ☐ 0-Unaided; ☐ 1-with devices in tub/shower; ☐ 2- intermittent A of 1 in tub/shower; ☐ 3- Assist of 1 in tub/shower; ☐ 4- Indep outside of tub/shower; ☐ 5- Assist of 1 outside of tub/shower; ☐ 6-Dependent
M1840 Toilet Transfer: ☐ 0-Indep ☐ 1-Assisted; ☐ 2- Uses BSC; ☐ 3-Uses bedpan/urinal; ☐ 4-Dependent
M1850 Transfers: ☐ 0-Indep; ☐ 1-Min A or w/device; ☐ 2- Can pivot; needs A; ☐ 3-Total A; ☐ 4- Bedfast; can position self; ☐ 4-Bedfast; bedbound
M1860 Ambulation: ☐ 0-Unaided level & stairs; ☐ 1-w/1 handed device level & stairs; ☐ 2-w/2handed device level & A w/stairs; ☐ 3- Walks only w/A; ☐ 4- Chairfast & can wheel indep ☐ 5- Chairfast & unable to wheel self; ☐ 6-Unable to amb or be in chair
Limited/Restricted:_____
DME/Assistive Devices: ☐ Cane ☐ Walker ☐ WC ☐O2 ☐ Hospital Bed ☐ BSC ☐ Splints ☐ Braces ☐ Other:

COMMUNITY/OTHER RESOURCES: ☐ Meals ☐ Transportation ☐ Private Assistance ☐ Other:_____
Private Caregiver Available: ☐ Yes ☐ No Follow Up with Physician:

PROGRESS TOWARD GOALS: Provide objective measures of improvement &/or functional progress toward goals

GOAL	STATUS at LAST REPORT	STATUS THIS DATE
☐ Short Term ☐ Long Term		
☐ Short Term ☐ Long Term		
☐ Short Term ☐ Long Term		
☐ Short Term ☐ Long Term		
☐ Short Term ☐ Long Term		

Provide SUMMARY of care and JUSTIFICATION as to why the client benefitted from skilled therapy services. Relate the results to functional outcomes.

NOTIFICATION OF DISCHARGE/TRANSFER:	FAXED TO:
Physician ☐Yes ☐No Client / Caregiver ☐Yes ☐No	

Therapist Signature & Professional Designation: **DATE:**