Rehabilitation Hospital of Maryland

PHYSICAL THERAPY
DISCHARGE SUMMARY

Patient's Name_____ **Diagnosis**_____
MR #_____ **Discharge Date**_____

D/C Status	I	Mod I	DS	CS	CG A	Min A	Mod A	Max A	D	Comments
Bed Mobility										
Transfers										
W/C Mobility										
Ambulation										____ft w/_____(A.D)
Stairs										# of stairs____w/____HR's
Curbs/Ramps										
Community Re-entry										

ROM_____ **/ Extension lag**____
Patient/Family Training Completed: ☐**Yes** ☐**No**
Comments:_____

_____

Equipment Recommended/ Provided:
☐**W/C(rental/purchase)** ☐**Cushion**_____ ☐**Walker (SW/RW)**
☐**Cane (SPC/QC)** ☐**Crutches (Axillary Crutches/Loftstrand)** ☐**N/A**
Other:_____

Equipment Checkout Completed: ☐**Yes** ☐**No** ☐**N/A**
Comments:_____
All Goals Met: ☐**Yes** ☐**No**
Comments:_____

_____

_____

_____

Home Exercise Program provided and reviewed: ☐**Yes** ☐**No**
Discharge Instructions/Plan for Follow-Up:

_____

_____

_____

Therapist Signature/License #/Date
Origination 7/05/04 Approved 10/27/04