Occupational Therapy Discharge Plan

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

Therapist Name: [Insert Therapist Name]

Facility Name: [Insert Facility Name]

Reason for Discharge

[Brief description of the patient's progress and reason for discharge]

Summary of Therapy

[Summary of therapy received, goals met, and any relevant interventions]

Discharge Recommendations

- [Recommendation 1]
- [Recommendation 2]
- [Recommendation 3]

Follow-Up Care

[Details on follow-up appointments or additional services needed]

Signatures

Therapist Signature: _____

Patient/Guardian Signature: _____

If you have any questions, please contact us at [Insert Contact Information].