matrix
HOME HEALTH CARE

Transfer/Discharge Summary

Client Name: ____________________

Start of Care Date: ____________________ Last Date of Service: ____________________

Discharge Date: ____________________ Diagnosis: ____________________

Physician Name: ____________________ Telephone Number: ____________________

Description of Care Provided:

Instructions Given to Patient:

Were Goals of Service met? If not, why?

Patient's condition at time of Transfer/Discharge:

Discharge assessment completed Yes ________ No ________

If no why?____________________

Check all that apply:

- ❐ Patient agreeable with discharge
- ❐ Physician notified of discharge
- ❐ Patient referred to outpatient services
- ❐ Patient to follow up with physician
- ❐ Other: ____________________

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Signature Date

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