

McLAREN FLINT
Flint, Michigan
PHYSICAL THERAPY
DISCHARGE EVALUATION

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Patient Name: _____

Diagnosis: _____

Referring Doctor: _____

Initial Evaluation Date: _____

Discharge Date: _____

The patient was seen in PT for ____ visits ____ no shows ____ cancellations.

Treatments consisted of: _____

SUBJECTIVE: _____

Pain: Initial pain scale rating: _____

Discharge pain scale rating: _____

Comments: _____

Sleep Pattern: _____

FUNCTIONAL IMPROVEMENT(S): _____

OBJECTIVE: _____

Orientation/Mentation: _____

Sensation: _____

Observation: _____

Posture: _____

Palpation: _____

Gait: _____

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Range of Motion:

Strength:

Special Tests: _____

Home Exercise Program: _____

Equipment Provided: _____

Patient/Family Instruction: _____

ASSESSMENT & CLINICAL IMPRESSION: _____

The following functional long term goals were achieved: _____

Patient Goals Achieved: _____

Outcome Tool: _____ Initial score: _____ Discharge Score: _____

PLAN: _____

Ongoing Prognosis: _____

Thank you for the referral.