



McLaren Flint  
Neurologic Rehabilitation Institute  
Social Work Discharge Summary

**Summary Of Progress During Treatment** (summary of goals, objectives, expectations/outcome achieved or not achieved):

---

---

---

---

---

---

---

---

---

---

---

---

**Discharge/Transfer Plan** (recommendation, referral, ongoing needs and plans to meet them; plans for medication, management; client’s input regarding recommendation and plans—may refer to Aftercare/Recovery Plan if applicable):

---

---

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
**Therapist Signature**

\_\_\_\_\_  
**Date/Time**

\_\_\_\_\_  
**Psychiatrist Signature (if required)**

\_\_\_\_\_  
**Date/Time**

\_\_\_\_\_  
**Clinical Reviewer Signature (if required)**

\_\_\_\_\_  
**Date/time**

PT.
MR.#/P.M.
DR.