Helping Hand
HEALTHCARE SERVICES

Transfer/ Discharge Summary

HOME HEALTH CARE

Client Name: _____

Start of Care Date: _____ Last Date of Service: _____

Discharge Date: _____ Diagnosis _____

Reason for Providing Services:

Services Provided:

Were Goals of Service met? If not, why?

Patient's condition at time of Transfer/Discharge:

Check all that apply:

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

Signature _____ Date _____