

SIHO Occupational Therapy Discharge Assessment

Patient Name: _____	Member ID # _____
Date: _____	Facility: _____
Therapist: _____	

1. Length of Treatment: _____
2. Number of Sessions: _____
3. Functional Limitations at Evaluation? _____
4. Functional Limitations at Termination: _____
5. Were Treatment Goals Met? Yes No

- If not, why not?
- Patient prematurely terminated
 - Patient moved away
 - Patient resistance
 - Treatment was inadequate
 - Other (explain)

6. Are additional services likely to be needed in the future? Yes No

_____ _____
 Therapist Signature Date

js/01/01