PLEASE FAX TO 812-378-7054

SIHO Physical 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