**Discharge Summary**

Patient’s Name:

Date of Initial Assessment:

Date of Discharge:

Number of session:

Presenting problem/symptoms:

Summary of treatment:

Reason for Discharge:

Recommend continued treatment

No further treatment recommended/needed

Recommendation (include referrals provided)

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Therapist’s signature |  | Therapist’s printed name and license number |
|  |  |  |
| Date |  |  |