

Speech Therapy Discharge Summary

I. Patient Information

[Patient's Name]: [Enter patient's full name]

[Date of Birth]: [Enter patient's date of birth]

[Medical Record Number]: [Enter patient's medical record number]

[Admission Date]: [Enter admission date]

[Discharge Date]: [Enter discharge date]

[Referring Physician]: [Enter referring physician's name]

The discharge summary of **[Patient's Name]** from speech therapy services provides a comprehensive overview of the therapeutic interventions, progress, and recommendations made during the course of treatment. **[Patient's Name]** has received individualized speech therapy services aimed at addressing **[Specify Speech or Language Disorder]**. As **[Patient's Name]** transitions out of speech therapy, this summary outlines the achieved goals and provides guidance for continued progress.

II. Assessment and Goals

A. Initial Assessment

[Patient's Name]'s speech and language abilities were initially assessed to determine the nature and severity of the disorder. This included evaluation of articulation, fluency, voice quality, language comprehension, and expression. Specific areas of deficit were identified to guide treatment planning.

B. Treatment Goals

Based on the assessment findings, individualized treatment goals were established in collaboration with **[Patient's Name]** and their caregivers. These goals focused on improving **[Specify areas of improvement]** to enhance communication effectiveness and quality of life. Progress towards these goals was regularly monitored and adjusted as necessary.

Example Discharge Report Speech Therapy

BM King



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