LEA:_____

Plan of Care
Discharge
Rehabilitation Services

1. _____
Student Name

2._____
DOB

3. _____
Medicaid Number

4. _____
School

5. Discipline: ____ Speech _____ PT _____ OT

6. Reason for Discharge

_____

_____

_____

_____

7. Discharge Plan (functional outcome):
____ Independent Home
____ Independent with assistive device(s)
____ Requires assistance
____ Requires supervision
____ Dependent

8. Discharge Disposition:
____ Home ____ Hospital
____ Other (specify)

_____

9. Date of Discharge: _____

10._____ _____
Signature/Title of Therapist **Date**