

Discharge Summary Template

Patient Information and Admission Details

Patient Name:

Date of Birth:

Medical Record Number:

Admission Date:

Discharge Date:

[Patient Name], a [age]-year-old [male/female] with a history of [relevant medical history], was admitted on [admission date] due to [primary reason for admission]. The patient presented with [chief complaints]. On admission, the patient was [stable/unstable] and in [mild/moderate/severe distress], requiring [oxygen therapy type and flow rate, etc.] due to [reason].

Summary of Clinical Course

Initial [relevant tests] revealed [findings], and [imaging study] showed [findings]. The patient was managed with [treatment plan]. The status improved, and by [date], the patient was successfully [action].

On [date], the patient developed [new symptoms], prompting further evaluation. [Diagnostic test] revealed [findings]. The patient was started on [medication], with resolution of symptoms by discharge. The hospital course was otherwise [unremarkable/ significant for...], and the patient remained [stable/required additional interventions].

[Any additional treatments] was initiated. By [discharge date], the patient was deemed clinically stable for discharge with instructions to continue the management plan.

Discharge Medications

At discharge, the patient was prescribed:

1. **[Medication Name]** – [Dosage and instructions]
2. **[Medication Name]** – [Dosage and instructions]
3. **[Home Medications, if continued]** – [Dosage and instructions]

Follow-up Plan and Continuing Care

The patient was advised to follow up with [primary care physician/specialist] in [timeframe] for reassessment of [condition] and medication review.

Additionally, a referral to [specialist] was made for ongoing management and optimization of [treatment]. The patient was encouraged to attend [treatment] to improve [health condition].

Patient Education and Lifestyle Recommendations

Comprehensive discharge education was provided, emphasizing the importance of medication adherence, symptom monitoring, and lifestyle modifications. The patient was instructed to seek medical attention if experiencing [worsening symptoms].

Additional guidance was provided on [nutrition, hydration, physical activity, smoking cessation, or any other relevant aspects]. The patient was advised to maintain an [active lifestyle, dietary modifications. etc.] while avoiding [excessive exertion, environmental triggers, etc.].

Prognosis and Overall Status at Discharge

The patient's prognosis is [status], provided that [adherence to treatment plan, follow-up compliance, etc.]. The patient was discharged on [discharge date] with a structured care plan in place to support ongoing [condition] management and recovery.

Physician Name:

Designation:

Contact Information: