DISCHARGE SUMMARY

Patient Details:
Name: John Doe
Date of Birth: 15 March 1985
Gender: Male
Medical Record Number: 123456789
Admission Date: 01 February 2025
Discharge Date: 08 February 2025
Attending Physician: Dr. Emily Carter, MD
Consultant: Dr. Robert Sinclair, MD (Cardiology)

Primary Diagnosis:
- Acute Myocardial Infarction (ST-Elevation)

Secondary Diagnoses:
- Hypertension
- Type 2 Diabetes Mellitus
- Hyperlipidemia
- Obesity (BMI: 32)

Procedures Performed:
- Coronary Angiography (02 February 2025)
- Percutaneous Coronary Intervention (PCI) with Drug-Eluting Stent Placement (03 February 2025)

Clinical Course:

Mr. John Doe was admitted to the hospital on 01 February 2025 via the emergency department after experiencing severe chest pain radiating to his left arm. Initial ECG showed ST-elevation in leads II, III, and aVF, suggestive of an acute inferior wall myocardial infarction. Emergency coronary angiography was performed, revealing a 95% occlusion in the right coronary artery (RCA). On 03 February 2025, percutaneous coronary intervention (PCI) was performed successfully with the placement of a drug-eluting stent.

Post-procedure, the patient was monitored in the cardiac intensive care unit (CICU) for 48 hours. He was initiated on dual antiplatelet therapy (DAPT) with aspirin and ticagrelor, along with atorvastatin, beta-blockers, and ACE inhibitors. His post-procedural course was uneventful, with no further episodes of chest pain. Serial cardiac enzyme levels showed a downward trend, and follow-up ECGs demonstrated resolving ST elevations. His blood glucose levels were managed with insulin during hospitalization due to elevated fasting glucose. A dietitian was consulted for diabetes and weight management, and a structured cardiac rehabilitation plan was discussed.

Vital Signs on Admission:
- Blood Pressure: 160/95 mmHg (Elevated)
- Heart Rate: 102 bpm (Tachycardic)
- Respiratory Rate: 18 breaths per minute
- Temperature: 98.6°F (Normal)

- Oxygen Saturation: 98% on room air

Vital Signs on Discharge:
- Blood Pressure: 125/80 mmHg (Controlled)
- Heart Rate: 78 bpm (Normal)
- Respiratory Rate: 16 breaths per minute
- Temperature: 98.4°F (Normal)
- Oxygen Saturation: 99% on room air

Laboratory Results:
- Troponin I (Initial): 5.8 ng/mL (Elevated)
- Troponin I (Discharge): 0.2 ng/mL (Normalizing)
- Total Cholesterol: 245 mg/dL (Elevated)
- LDL: 160 mg/dL (Elevated)
- HDL: 38 mg/dL (Low)
- HbA1c: 8.2% (Elevated, indicating poor diabetes control)
- Serum Creatinine: 0.9 mg/dL (Normal)
- Electrolytes: Normal

Medications on Discharge:
1. Aspirin 81 mg daily
2. Ticagrelor 90 mg twice daily
3. Atorvastatin 80 mg daily
4. Metoprolol 50 mg twice daily
5. Lisinopril 10 mg daily
6. Metformin 1000 mg twice daily
7. Insulin Glargine 10 units at bedtime
8. Nitroglycerin as needed for chest pain

Discharge Instructions:
- Continue prescribed medications as directed.
- Monitor blood pressure and blood glucose levels at home.
- Follow a heart-healthy, low-fat, low-sodium diet.
- Engage in light physical activity as tolerated, progressing to moderate exercise as per the cardiac rehabilitation plan.
- Avoid smoking and alcohol consumption.
- Recognize warning signs of heart attack (chest pain, shortness of breath, dizziness) and seek immediate medical attention if symptoms recur.
- Follow up with primary care physician in one week.
- Cardiology outpatient follow-up in two weeks.

Follow-up Appointments:
1. Primary Care Physician: 15 February 2025
2. Cardiology Clinic: 22 February 2025
3. Cardiac Rehabilitation Program: Scheduled for 20 February 2025

Discharging Physician:
Dr. Emily Carter, MD
Department of Cardiology
City General Hospital
123 Main Street, Suite 400
Metropolis, ST 54321

Phone: (555) 123-4567
Fax: (555) 987-6543
Email: ecarter@citygeneralhospital.com

Patient Acknowledgment:
I have reviewed the discharge instructions and understand my medications and follow-up care.
Patient Signature: _____
Date: 08 February 2025

End of Discharge Summary