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COUNTY MEDICAL

CENTRE

**DISCHARGE SUMMARY**

**Patient Name:** ................................................................................  
**Admission No.:** .............................................................................  
**DOA:** ..............................................................................................  
**DOD:** ..............................................................................................  
**Age:** ...............................................................................................  
**Sex:** ...............................................................................................

**Diagnosis:** ....................................................................................

**History**..........................................................................................................................................................................................................

**ClinicalFindings**............................................................................................................................................................................................

**LabResults**....................................................................................................................................................................................................

**MedicationsGiven**.........................................................................................................................................................................................

**Discharge Drugs:** ........................................................................

**Review Date:** ...........................................

**Doctor's Name:** .........................................................

**Signature…………………………………..**