Very Important Hospital

Somewhere

Anywhere

Postcode

Phone number

INPATIENT DISCHARGE SUMMARY

Patient Name: Harry Barnes D.O.B: 01/09/1957 NHS Number: 4879235646

Date of Admission: 04/10/2017 Date of Discharge: 29/10/2017

Diagnosis: Fractured left neck of femur

Other Conditions: COPD, Osteoporosis

Procedures and Therapies: Surgical intervention

Complications: Post-operative DVT

Summary of admission and assessment: Admitted following mechanical fall sustaining fracture left neck of femur. Underwent surgical fixation with good result. During admission developed post-operative left calf swelling and pain. DVT popliteal vein on scan. Commenced on treatment dose Tinzaparin and discharged on NOAC.

Investigations: Xray, Blood tests, USS scan lower limb, ECG.

Follow up Plans: Physiotherapy, Orthopaedic outpatient appointment in 3 months.

Discharged to: Home with outpatient follow up.

Signed by: _____

Responsible Consultant: Mr Boneman

Date and Time: 29/10/2017

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INPATIENT DISCHARGE SUMMARY

Patient Name: Sally Browne D.O.B: 19/01/2010 NHS Number: 4758390276

Date of Admission: 20/12/2016 Date of Discharge: 21/12/2016

Diagnosis: Tonsillitis

Other Conditions: Asthma

Procedures and Therapies: IV antibiotics, IV fluids, observation, IV medicatons (other)

Complications: Nil

Summary of Admission: Admitted with sore throat, pyrexia, difficulty eating a drinking. Treated according to guudelines. Able to eat and drink, well to go home with close family input.

Investigations: Blood tests, urine sample.

Follow up Plans: Nil

Discharged to: Home

Signed by: _____

Responsible Consultant: Mr ENT

Date and Time: 21/12/2016

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INPATIENT DISCHARGE SUMMARY

Patient Name: Kieran Hart D.O.B: 14/02/1990 NHS Number: 6789236745

Date of Admission: 04/02/2017 Date of Discharge: 15/02/2017

Diagnosis: Acute cholecystitis with gallstones.

Other Conditions: Obesity

Procedures and Therapies: Laparoscopic cholecystectomy

Complications: Post-operative wound infection

Summary of Admission: Admitted with right upper quadrant pain, vomiting, fever. Treated as per sepsis protocols. Found to have acute cholecystitis and gallstones. Underwent cholecystectomy. Developed erythema and pus around wound site requiring re-investigation and washout. Improved on IV antibiotics.

Investigations: USS abdomen, Xray, Blood tests, urine dip, microbiology.

Follow up Plans: Surgical outpatient in 2 weeks

Discharged to: Home with outpatient follow up

Signed by: _____

Responsible Consultant: Mr Scalpel

Date and Time: 15/02/2017

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INPATIENT DISCHARGE SUMMARY

Patient Name: Nina Roberts D.O.B: 09/03/1945 NHS Number: 4758936746

Date of Admission: 01/01/2015 Date of Discharge: 01/04/2015

Diagnosis: Subdural haematoma

Other Conditions: Ischaemic heart disease, atrial fibrillation, vascular dementia

Procedures and Therapies: Neurosurgical intervention, physiotherapy

Complications: Hospital acquired pneumonia

Summary of Admission: Unwitnessed fall at home on anticoagulation with amnesia. Admitted with Low GCS. Found to have bilateral subdural haematomas requiring neurosurgical intervention. Closely monitored with recovering consciousness and requiring intensive physiotherapy. Developed cough with sputum production and temperature during admission. Treated with IV antibiotics for hospital acquired pneumonia. Discharged to care home.

Investigations: CT scan, Xray, Blood tests, microbiology

Follow up Plans: Home GP follow up

Discharged to: Nursing home

Signed by: _____

Responsible Consultant: Mr Brain

Date and Time: 01/04/2015

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INPATIENT DISCHARGE SUMMARY

Patient Name: George Harrison D.O.B: 02/04/1975 NHS Number: 9758436754

Date of Admission: 05/11/2016 Date of Discharge: 03/12/2016

Diagnosis: Intentional drug overdose and alcohol dependence

Other Conditions: Type 2 Diabetes, hypothyroidism.

Procedures and Therapies: IV medication (other), oral medication (other).

Complications: Nil

Summary of Admission: Admitted following intentional overdose due to low mood surrounding current social circumstances. Observed and commenced on alcohol detoxification regime. Reviewed by specialist nurses in drug and alcohol team and psychiatry team. Social services involved due to no fixed abode. Commenced on anti-depressants and discharged with community follow up.

Investigations: Blood tests, ECG, Ultrasound scan, physical observations, blood glucose.

Follow up Plans: Community specialist nurse input

Discharged to: Home, social input

Signed by: _____

Responsible Consultant: Mr Mood

Date and Time: 03/12/2016