Discharge-Day Progress Note
Patient: Anderson, John
MRN: 12345678
DOB: 05/19/1965 (Age: 60)
Date: 2025-08-04
Hospital Day: 4
Admit Date: 2025-08-01
Service: Internal Medicine
Attending Physician: Dr. Emily Tran, MD
Author: Emily Tran, MD

S: Subjective

Patient is a 60-year-old male who was admitted with community-acquired pneumonia involving the right lower lobe. This morning, he reports significant improvement in symptoms. No fever overnight. He endorses a mild non-productive cough but denies dyspnea, orthopnea, chest pain, dizziness, nausea, or chills. Appetite has returned; tolerating a regular diet. Denies bowel or bladder complaints. Reports good sleep. Ambulating independently without difficulty. No concerns about discharge. Patient is aware of diagnosis, treatment course, and follow-up instructions. He verbalizes understanding and agreement with discharge today.

O: Objective

Vital Signs:

- T: 36.7°C (oral)
- HR: 78 bpm
- BP: 126/74 mmHg
- RR: 16
- SpO_2: 96% on room air

Physical Exam:

- **General:** Alert cooperative, in no acute distress. Sitting upright in bed, conversing normally.
- **HEENT:** Normocephalic, atraumatic. Oropharynx moist, no erythema or exudates.
- **Neck:** Supple. No lymphadenopathy or JVD.
- **Cardiovascular:** Regular rate and rhythm, no murmurs, rubs, or gallops. Distal pulses intact.

- **Respiratory:** Improved breath sounds bilaterally. Mild inspiratory crackles at the right lower lobe. No wheezing or accessory muscle use.
- **GI:** Soft, non-tender, non-distended. Normoactive bowel sounds. No hepatosplenomegaly.
- **GU:** Deferred.
- **Extremities:** No edema, no cyanosis or clubbing.
- **Skin:** Warm, dry, intact. No rashes or lesions.
- **Neuro:** Alert and oriented ×3. Cranial nerves II–XII grossly intact. No focal deficits.
- **Psych:** Normal mood and affect. Cooperative.

Functional Status: Ambulating independently with steady gait. No assistive devices required. No occupational or physical therapy needs.

Labs (most recent):

- **CBC:**
  - WBC: 9.2 ×10⁹/L (↓ from 12.3 at admission)
  - Hgb: 13.7 g/dL
  - Hct: 40.2%
  - Plt: 235 ×10⁹/L
- **BMP:**
  - Na: 138 | K: 4.1 | Cl: 102 | HCO_3: 25
  - BUN: 12 | Cr: 0.9 | Glu: 98
- **LFTs:** WNL
- **CRP:** 21.4 mg/L (↓ from 56.2 mg/L)
- **Procalcitonin:** 0.08 ng/mL (normalized)
- **Blood Cultures (x2):** No growth at 48 hours
- **Respiratory Pathogen Panel:** Negative
- **CXR (08/03):** Interval improvement in right lower lobe infiltrate; no new consolidation or effusion.

A: Assessment

60-year-old male with no significant past medical history, admitted with community-acquired pneumonia (CAP), right lower lobe (RLL), now clinically stable and meeting criteria for safe discharge. Hospital course was uncomplicated. He completed 3 days of IV ceftriaxone and azithromycin, transitioned to oral azithromycin on hospital day 3.

Patient has been afebrile >48 hours, oxygenating well on room air, with improving symptoms and laboratory markers. Tolerating oral intake, ambulating independently, and demonstrating understanding of medication regimen and follow-up.

P: Plan

Disposition:

- Discharge to home today with daughter as primary caregiver.

Antibiotics:

- Continue oral azithromycin 500 mg daily to complete 5-day course (currently on day 3 of 5).
- No additional antimicrobials indicated. Patient educated on adherence and possible side effects.

Follow-Up:

- **Primary Care:** Dr. Laura Greene, MD – within 5–7 days for post-hospital follow-up, medication review, and re-assessment. Appointment scheduled for 08/09 at Stanford Primary Care.
- **Imaging:** Outpatient repeat chest X-ray in 6 weeks to ensure resolution of infiltrate. Order placed.

Education & Counseling:

- Discussed diagnosis, expected course of recovery, warning signs (e.g., fever, worsening cough, dyspnea, pleuritic pain), medication use, and follow-up.
- Patient verbalized understanding. Daughter present for counseling and provided with written discharge instructions.

Immunizations:

- Pneumococcal vaccine status unknown – recommended to PCP for outpatient review.
- Flu vaccine and COVID-19 booster up to date.

Medications Reconciled:

- No home medications.
- Discharge medications:
    - Azithromycin 500 mg PO daily × 2 more days
    - Acetaminophen 650 mg PO PRN for fever or myalgias

Physical/Occupational Therapy:

- No current needs. Patient independent with ADLs and mobility.

Social Work / Case Management:

- Cleared for safe discharge home with daughter. No equipment needs. No home health services required at this time.

DC Summary:

- Dictated and available in chart.

Signed:
Emily Tran, MD
Attending Physician, Internal Medicine
08:20 AM, 2025-08-04