

Patient Name: **Subir Nath Bhowmik**
Age / Sex: **20 Yrs / Male**
DOB: **2005**
PID: **CX-10245**

Admission Date: **05/01/2026**
Discharge Date: **10/01/2026**
Consultant: **Dr. R. Sharma**

DISCHARGE SUMMARY

CHIEF COMPLAINT: High Grade Fever with chills for 3 days.

HISTORY OF PRESENT ILLNESS: Patient presented with complaints of high-grade fever (up to 104°F) associated with severe chills, rigor, generalized body ache, and headache for the past 3 days. No history of cough, breathlessness, or urinary symptoms.

PAST MEDICAL HISTORY: No significant past medical history. No known allergies.

PAST TRAVELING HISTORY: History of recent travel to a malaria-endemic region (Odisha) 10 days ago.

VITAL SIGNS (On Admission): Temp: 103.6°F, Pulse: 112/min, BP: 110/70 mmHg, RR: 22/min, SpO₂: 98% on room air.

PHYSICAL EXAMINATION: General condition: Conscious, oriented, febrile, dehydrated. Pallor present. No icterus, cyanosis, clubbing, or lymphadenopathy.

Systemic Exam: CVS: S1, S2 heard, no murmurs. Resp: Bilateral air entry clear. P/A: Soft, mild splenomegaly noted, non-tender. CNS: No focal neurological deficit.

HOSPITAL COURSE & TREATMENT: Patient was admitted and investigated. Rapid Malaria test was positive for P. falciparum. Started on IV fluids, antimalarials (Artesunate combination therapy), antipyretics, and supportive care. Fever subsided by day 3. Patient became afebrile and symptomatically better.

DISCHARGE CONDITION: Stable, afebrile, vitals stable.

DISCHARGE INSTRUCTIONS: Complete the course of oral antimalarials as prescribed. Plenty of oral fluids. Follow up in OPD after 5 days. Review immediately if fever recurs.

Admitting Doctor Signature

Dr. A. Singh

Dr. A. Singh

Treating Doctor Signature

Dr. R. Sharma

Dr. R. Sharma, MD (Med)

Discharge Officer Signature

Mr. K. Das

Mr. K. Das