Discharge Summary

PATIENT NAME:
MRN:
DATE OF ADMISSION:
DATE OF DISCHARGE:
ATTENDING: DICTATING:

ADMISSION DIAGNOSES: (list everything including chronic conditions, ie obesity) DISCHARGE DIAGNOSES: (same, list all relevant to admission as well as those diagnosed during the patients stay and then chronic conditions)

H&P: Read the admission H&P and be sure to include the following
CC: HPI: POBHx: PGYNHx: PMHx: PSHx:
MEDS on admission: ALL:
SHx: FHx:
PHYSICAL EXAM ON ADMISSION: (again read this off H&P, if not much info given can say "relevant for …." and include what information is given)
LABORATORY RESULTS: IMAGING RESULTS:
ASSESSMENT/PLAN: (again can read off H&P) HOSPITAL COURSE:
This is where you actually have to think. It is best to do the hospital course by system so that you can keep things straight. Basically you need to break it down and then discuss relevant interventions/results/consults/events/etc for each system. If you have things that overlap you can say "see above for details" if you have already gone through a related issue (i.e. postop pain and then pt had desat due to pain meds, you would dictate PAIN section and then under RESP can say had desat on day _ and was managed as stated above)

DISCHARGE: Discharged to home on __in stable condition

DISCHARGE MEDICATIONS: List all meds as written on dc ppwk

DISCHARGE INSTRUCTIONS: Basically go through instructions on dc ppwk (use as much detail as you want)

FOLLOW-UP: List all scheduled follow-up appointments or can say "patient instructed to call Dr. _____to make follow-up appointment for one week)

** VERY IMPORTANT: when you sign your dictation BE SURE to cc the referring MD (you can find this in the provider tab)