DISCHARGE SUMMARY GUIDELINES

Patient name: _____

MRN: _____

Admission date: _____

Discharge date: _____

Attending physician: _____

Referring physician: _____

Resident physician: _____

Discharge Diagnoses:
(*Include also functional, cognitive, behavioral, and affective diagnoses*)

Procedures performed during admission:

Reasons for hospitalization, and hospital course:
Describe hospital course for each active problem example; #1. Heart failure, #2Falls, etc.

Discharge Instructions (e.g., wound care, activity, diet, red flags):

Discharge medications:
(Which medications or doses are new? Tapering schedules?)
(Which of the pre-admission drugs are to be held or discontinued?)
(Indication for each drug?)

Rehabilitation Orders:

Follow-up Appointments:

Pending laboratory or other studies:

Family/Caregiver/Surrogate decision maker:

Healthcare Treatment Goals, Preferred Intensity of Care, Code Status:

Functional Status at Transfer:

Dictated by: _____

CC:_____
(to include copies to primary care providers, hospital consultants, next venue of care (SNF, etc.) or home health agency)