DISCHARGE SUMMARY OUTLINE

I. Beginning of Report
   a. Your Name with spelling.
   b. Patient Name, DOB, Medical Record Number
   c. Attending Name.
   d. Dates of Admission and Discharge

II. Diagnosis(es):
   a. List Injuries: include operation and operative date
   b. List chronic/acute diseases
   c. Incidental Findings and plan. Example - Renal Cysts – PCP in 1-2 weeks.

III. Consults and Follow up appointments
   a. Ortho, PT/OT, Speech, etc
   b. List all follow up appointments and for consult service list the consult attendings name (ie, Spine- Dr. France- 2 weeks)

IV. Discharge Medications
   a. List all new medications or changed medications from this hospitalization.
   b. List previous home medications that need to be discontinued or continued

V. Discharge Instructions
   a. Diet
   b. Activities/Weight bearing status
      i. Include all types of assistive devices (Walker, Sling, or Miami J collar)
      ii. Wound Care Instructions: How often to change dressings/with what/how.
   c. Disposition. Examples - Home vs Rehab

II. HPI
   a. Listing Initial information.
      i. Patient age/gender, incident, date of injury.
      ii. Arriving Vital Signs/GCS/Physical Exam and Labs
      iii. Radiographic Work up with findings (don't forget FAST/EKG)

   b. Hospital Course
      i. Pertinent initial interventions (IR, FFP)
      ii. Initial consulting services and suggestions
      iii. List pertinent problems and injuries. List all pertinent problems throughout course (pneumonia, DVT, PE, etc with appropriate treatment.) Be sure to describe entire hospital course including ICU.
      iv. Ensure all operative dates and procedures are included.

Reviewed 1/14/17