Discharge Summary Format

1. Date of admission (xx/xx/xxxx)
2. Date of discharge (xx/xx/xxxx)
3. Attending physician (name)
4. Primary care physician (name)
5. Consultations during hospitalization (name, medical/surgical specialty)
6. Discharge diagnoses (list specific diagnoses and not symptoms or signs)
7. Secondary diagnoses (list all other active medical problems for which the patient is under treatment)
8. History of presenting illness (brief summary/snapshot of how the patient presented to the hospital; apx. 3-5 lines)
9. Hospital course (this is the most important component of the discharge summary; organize by specific problems treated or addressed during this hospitalization or by organ systems if the patient is highly complex with multi-organ system disease; providing important details in a coherent manner regarding the patients hospital course, without being overly wordy, is critical)
10. Pertinent laboratory data (list only specific test results that were important in the management of this patient)
11. Pertinent radiologic data (list all radiologic tests, date, and interpretation)
12. Pertinent procedures (list all procedures/surgeries the patient underwent during hospitalization, date, and outcome)
13. Pending laboratory studies (list all pending lab tests at the time of discharge)
14. Discharge medications (list all medications the patient will be taking following discharge from the hospital by name, dosage, route, and frequency; avoid abbreviations like QD or IU and instead dictate daily or international units; this list must exactly match the discharge medication list the patient receives on day of departure)
15. Discharge instructions (list specific details and actions regarding wound care, and symptoms or signs the patient should be aware of following hospitalization, i.e. if a patient with CHF notices worsening edema, SOB and weight gain, they should double their lasix dose and call their PCP; clearly state who the patient should contact in case symptoms worsen; describe

lifestyle counseling or coaching provided during the hospitalization, i.e. smoking cessation and alcohol misuse/abuse counseling)

16. Diet (recommend specific dietary instructions, i.e. low-sodium, low fat, heart healthy; dysphagia II diet, etc.)
17. Activity (recommend specific activity level the patient may return to. i.e. gradual return to normal activity, non-weight bearing for 4 weeks, etc.)
18. Follow-up (name of doctor, appointment location, date and time; if the patient will be making an appointment at a later date, clearly specify this; provide a timeframe by which you would like the patient to be seen in clinic)
19. C.C. (send a copy of the discharge summary dictation to all relevant healthcare providers including the attending of record, consultant and the patients PCP; if the patients PCP is not part of the Sinai/Lifebridge system, clearly state their full name and office mailing address)