Inpatient Discharge Summary:

This is the same format as an interim summary or off-service note

This is usually a dictated report (at least in the Children's hospital), but the format is the same whether dictated or written.

Identify the note as a discharge summary.
Identify the admission date
discharge date
admit diagnosis
discharge diagnosis.

Identify procedures and consultations that occurred during the stay.

Identify the chief complaint and briefly review the HPI. Review the pertinent physical examination findings on admission. Review pertinent laboratory, radiology and other studies on admission.

Review the hospital course:

Two schools of thought exist on this topic. One can either review the hospital course in chronological order for the entire hospital stay i.e. hospital day 1 this happened, hospital day 2 this happened etc. or review the hospital course by organ system. The organ system approach makes most sense to the majority of clinicians although it usually leaves out some of the details that are captured in the chronological approach. Whichever you choose be as complete as possible. This document can be the most helpful evidence of previous admission if the patient is readmitted!

Following the hospital course identify discharge medications (frequency, dose, route, length of prescription), any restrictions (diet, exercise, driving etc.) and how follow-up will occur i.e. in an outpatient clinic, in the Emergency Department etc.

Sign your notes LEGIBLY and put your pager number after your signature.