Discharge Summary

As you begin, state that you want the transcriptionist to use the Pediatric Discharge Summary Template for the dictation

ADMISSION DATE:

DISCHARGE DATE:

ADMISSION DIAGNOSES: What you thought diagnosis was at admission based upon information available at that time. Also includes reason for admission if you don't have enough information to make a tentative diagnosis. At that point, the reason for admission may be based on symptoms only. Example: Fever without source.

DISCHARGE DIAGNOSES: What you have concluded is the diagnosis(es) based upon testing, studies, etc. Example: above diagnosis becomes UTI

CONSULTS: Include dates and findings/recommendations

PROCEDURES: Include the dates/findings for any procedures and radiographic studies

HPI: If a prior H&P is dictated in HIS you may reference same and then include a brief summary of what prompted the admission. No need to repeat family history, immunizations, etc. Assume the referring physician did not receive the dictated H&P and needs enough information to understand why the child was admitted. If the H&P is not in HIS, it is usually best to dictate the entire H&P so it is in the computer record. If not done by yourself, you should indicate by whom. For example, "H&P as taken by Dr. X." You may include the initial assessment, but there is no need to dictate plan as it should be incorporated into the Hospital Course.

HOSPITAL COURSE: Consider what information would be important to you as the primary, or another physician seeing this patient in follow-up. Please do some organization prior to dictating. Be succinct-pertinent positives and pertinent negatives. There is no need to be explicit as to each day's events. Neither do you have to recite all lab data, just pertinent lab data. You may organize by systems or problem-based. Problem-based appears to eliminate duplication and is preferable, but either format is certainly acceptable. The critical aspect is organization.

DISCHARGE DIAGNOSIS ASSESSMENT: One line summary

DISCHARGE TO: Usually home, but sometimes a facility

DISCHARGE CONDITION: Should be Good or Stable if they are going home!

DISCHARGE MEDICATIONS: Include doses, frequency and length of therapy

DISCHARGE INSTRUCTIONS: You must list them out, everything you checked or wrote on the discharge form– do not say "as listed in the medical record."

PENDING LABS: List all labs that are pending at the time of dictation. Labs may have come back between discharge and when you dictate the summary, so provide that information if it is available.

FOLLOW-UP: List all follow-up appointments with dates and time, name of physician or service, and phone number for the family to contact them.

CC: Ask for a copy to be sent to the primary care provider at the end of the dictation, including the PCP's fax, address and/or phone number expedites the process!