Inova Fairfax Hospital Department of Medicine
Suggested Discharge Summary Format
(Modified from OU-Tulsa Department of Internal Medicine)

Patient Name:
Admission Date:
Discharge Date:
Attending Physician:
Dictating Physician:
Admitting Diagnosis:
Discharge Diagnosis:

Principal discharge diagnosis (reason for hospital stay after hospital assessment)
Other discharge diagnoses which were addressed during hospital stay (Complete list of active problems addressed during hospital stay)

Consultations: (name and specialty)
Procedures: (Name of procedure and concise description of results, only major studies)
Complications (for primary and other discharge diagnoses):
History and Hospital Course:

A concise summation of clinical course. Begins from time of admission with a brief summary (one paragraph) of key data from H&P. Then, use a problem-oriented approach by writing a separate paragraph for each problem title followed by a short synopsis of the evaluation, treatment and progress of each problem. Problems should match diagnosis above. Must describe to what the problem was attributed, the intervention(s) which occurred and the outcome.

Avoid a laundry list of lab values: For example, simply say, "Chest X-Ray was unremarkable; CBC, serum chemistries, were normal with the exception of elevated potassium of 6.3." Do include lab values that will be of use in clinic follow-up – e.g. HbA1C, lipid profile, TSH. Results of procedures documented under "procedures" can be referred to and do not need to be repeated.

Discharge plan:

Condition upon discharge:
Activity:
Diet:
Date of next appointment and physician who will see patient

Medications at discharge:

Do not simply state "resume home medications."

Issues to be addressed at follow-up:
CC: Please instruct transcriber to cc all physicians who will follow up with the patient, especially the PCP.

Example

Patient Name: John Smith
Date of Admission: November 2, 2004
Date of Discharge: November 5, 2004
Attending Physician: Dr. ChinHee Kim
Dictating Physician: Dr. Ho
Admitting Diagnosis: Right Lower Lobe Pneumonia
Discharge Diagnoses:

Principal discharge diagnosis: Right Lower Lobe Pneumonia due to Streptococcus Pneumoniae
Other discharge diagnoses which were addressed during hospitalization:

1. Type 2 diabetes mellitus
2. Congestive Heart Failure due to idiopathic cardiomyopathy
3. Hyponatremia due to SIADH versus CHF

Consultations: None
Procedures: Echocardiogram – EF – 32%, global hypokinesis
Complications: None
History and Hospital Course:
The patient is a 55 year old white male who presented with typical symptoms of pneumococcal pneumonia with the initial chest X-Ray showing a right lower lobe infiltrate. An initial ABG revealed a respiratory alkalosis and a pO2 of 55 on room air.

1. Pneumonia – The patient was initially treated with ceftriaxone and azithromycin. Subsequent blood cultures revealed a sensitive pneumococcus. Symptoms improved and repeat chest X-ray did not reveal evidence of a pleural effusion. WBC count the day prior to discharge was 12,000 with a normal differential. Pulse oximetry was 95% on room air on the day of discharge,
2. Type 2 Diabetes – Initially, blood sugars were difficult to control. He was treated with basal, prandial, and correctional insulin with an average blood sugar of 150 on the day prior to discharge.
3. Congestive Heart Failure – The patient had a history of idiopathic cardiomyopathy with a normal cardiac catheterization in 2002. An echocardiogram was performed with results as above. Based on the improvement of his dyspnea with treatment of his pneumonia, it was thought that CHF was not the cause of his admitting symptoms. His lisinopril dose was increased from 10 mg to 20 mg daily.
4. Hyponatremia – The patient's initial sodium level was 126. This was thought to be due to either SIADH from his pneumonia or due to CHF. With the treatment above, his sodium improved and on the day prior to discharge was 137.

Other discharge labs: TSH – 3.4
Discharge Plan:

Condition on discharge: Much improved. Able to ambulate without difficulty.
Activity: No restriction.
Diet: 2000 calorie ADA
Follow up appt: the patient has an appointment to see Dr. Eric Bonura at the IFH discharge clinic at 8PM on 7/28/06.

Discharge Meds: Amoxicillin 500 mg PO tid x 10days, Lisinopril 20 mg PO qday, Furosemide 40 mg PO bid, Levothyroid 100 mcg PO qday, Atorvastatin 20 mg PO qday, aspirin 81 mg PO qday, Lantus 20 units SQ qhs, Humalog 4 units prior to each meal
Issues to be addressed at follow up – Assess tolerance of new lisinopril dose and consider addition of a beta blocker for management of CHF.
CC: Dr. Eric Bonura