DISCHARGE SUMMARY

FACILITY: _____

UNIT/ROOM: _____

ADMIT DATE: ____ / ____ / _____ DISCHARGE DATE: ____ / ____ / _____

MRN: _____

Patient Demographics

Patient Name: _____

DOB: ____ / ____ / _____

Phone: _____ Alt Phone: _____

Address:

_____

City: _____ State: _____ ZIP: _____

Preferred Language: _____ Interpreter Needed: ☐ Yes ☐ No

Emergency Contact: _____

Phone: _____

Primary Care Provider (PCP): _____

Phone: _____

Reason for Hospitalization

Admitting Diagnosis / Reason for Admission:

_____

_____

Diagnoses at Discharge

Primary Discharge Diagnosis:

_____

Secondary Diagnoses (if any):

1. _____
2. _____
3. _____

Major findings, treatments, events, or procedures (plain language if possible):

_____

_____

_____

Providers Involved During This Stay

Attending Physician: _____

Service: _____

Consulting Specialists (if any):

- _____Specialty: _____
- _____Specialty: _____
- _____Specialty: _____

Surgeon/Proceduralist (if applicable):
_____

Case Manager: _____

Social Worker: _____

Other key team members (optional):
_____

Discharge Status and Destination

Condition at Discharge: ☐ Stable ☐ Improved ☐ Guarded ☐ Other:
_____

Discharge To: ☐ Home ☐ Home w/ Home Health ☐ SNF ☐ LTAC ☐ Inpatient Rehab ☐ Other:
_____

Transportation: ☐ Family/Friend ☐ Wheelchair Van ☐ Ambulance ☐ Other:
_____
_____

Activity and Diet

Activity: ☐ As tolerated ☐ Fall precautions ☐ No driving ☐ No lifting > ____ lbs ☐ Other:
_____

Diet: ☐ Regular ☐ Cardiac ☐ Diabetic ☐ Renal ☐ Soft ☐ Thickened liquids ☐ Other:
_____

Prescription List

PRESCRIBER / CLINIC (Provider Completes)

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Provider Name (MD/DO/NP/PA): _____

NPI: _____ DEA (if applicable): _____

State License #: _____

PATIENT INFORMATION (Patient/Clinic)

Patient Name: _____ DOB: ____ / ____ / _____

Address: _____

Phone: _____

Allergies: _____

Weight (optional): _____

Diagnosis/Indication (optional): _____

PHARMACY

Pharmacy Name: _____

Phone: _____

Address/Location: _____

PRESCRIPTIONS (Provider)

Date Written: ____ / ____ / _____ Refills allowed until: ____ / ____ / _____ (if applicable)

Rx #1

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW (Dispense as Written)

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #2

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #3

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #4

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #5

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #6

Medication: _____

Strength/Form: _____

(Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #7

Medication: _____

Strength/Form: _____

Sig (Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #8

Medication: _____

Strength/Form: _____

Sig (Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #9

Medication: _____

Strength/Form: _____

Sig (Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____

Rx #10

Medication: _____

Strength/Form: _____

Sig (Directions):

_____

Dispense (#): _____ Refills: _____ Substitution: ☐ Allow ☐ DAW

Controlled Substance: ☐ Yes ☐ No ICD-10 (optional): _____