Discharge Summary

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A discharge summary is an account of the major events of the hospital admission for the patient's GP, so they can take over the patient's care.

Tips

- The summary is for another medical professional so abbreviations and medical jargon can be used.
- After you have completed the summary, it should be given to the patient's nurse so they can give it to pharmacy to get the medications, get it faxed to the patient's GP and give the patient a copy.

Demographics

- Patient
  - Name
  - Hospital number
  - DOB
  - Address
  - GP details
- Hospital stay
  - Consultant
  - Ward & hospital
  - Admission and discharge date
  - Discharge destination
- Summary details
  - Date written
  - Your name and signature

Clinical Details

- Presentation
  - History
  - Examination
- Investigations
  - Important investigation results
  - Any awaited results
- Diagnosis & patients co-morbidities
- Management
  - How the patient was managed/ treated
  - Complications

Future Management

- Management plans for after discharge
- Follow up appointment
- Actions for GP

Medications

- Regular medication changes
- Medications to take home (medication, strength, form, directions, quantity)
  - Regular medications
  - Any added medications
  - Any PRN medications still being used (e.g. analgesia, anti-emetics)

    N.B. Out-patient controlled drug prescriptions must: be in handwriting; include patient name and address; dose must be spelled out as well as numeric e.g. 5 (five) mg; total quantity must be spelled out as well as numeric

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