

Discharge Summary/Transfer Note/Off-Service Note Instructions

Date of Admission/Transfer:

Date of Discharge/Transfer:

Admitting Diagnosis: This should be your working *diagnosis* at the time of admission (not the chief complaint/presenting symptoms).

Discharge Diagnosis*: Make sure this is a diagnosis and not a symptom or sign. This will not be included on transfer summaries or off-service notes.

Secondary Diagnoses: Include all active medical problems regardless of whether they were diagnosed this admission. (Active medical problems include any condition for which the patient may be receiving treatment.)

Procedures: List all procedures with the date of occurrence

Consultations: List all consultations

History of Present Illness: Typically this is a brief snapshot of how they presented followed by the phrase “see dictated full H&P for details”. A good way to think about this is it is basically the same thing you would write as your 1-2 sentence summary statement under the assessment before you go into more details of your thought processes, differential, and plan.

Hospital Course: This is the most difficult part to write as you need to balance appropriate details with conciseness. A day-by-day account of the course is too detailed. For example, instead of *“he appeared to have pneumonia at the time of admission so we empirically covered him for community-acquired pneumonia with ceftriaxone and azithromycin until day 2 when his blood cultures grew out strep pneumoniae that was pan sensitive so we stopped the ceftriaxone and completed a 5 day course of azithromycin. But on day 4 he developed diarrhea so we added flagyl to cover for c.diff, which did come back positive on day 6 so he needs 3 more days of that...”* this can be summarized more concisely as follows: *“Completed 5 day course of azithromycin for pan sensitive strep pneumoniae pneumonia complicated by c.diff colitis. Currently on day 7/10 of flagyl and c.diff negative on 9/21.”*

Self-limited electrolyte abnormalities, minor medication adjustments, routine fluid administration are too detailed. Focus on major interventions with the rationale including any complications. For hospitalizations less than 3 days, a couple of sentences will likely suffice.

Condition*: For discharges this should always be “stable”.

Disposition*: This is where the patient is going. (e.g. “home with home health”, “daughter’s house”, “Shands rehab”, “ 8th floor, Psychiatry service”)

Discharge Medications: List all medications the patient needs to take at home including doses, route, frequency, and date of last dose when applicable. Do not list all the prn medications you wrote for them at the hospital unless there is something they really need. If you have changed any of the patient’s admission medications this should be noted along with the rationale. (The rationale may already have been stated in the hospital course, which is fine.)

Discharge Instructions*: Be specific about activity level, diet, wound care, symptoms and signs to report or seek care for (e.g. “call Dr. ___ if temperature greater than 100” or “go to ER if chest pain returns”). Try to anticipate specific needs related to your patient’s problems. This is also another good place to include statements like “patient counseled to avoid all tobacco and alcohol products”.

Follow-up*: Name of doctor, specialty, and appointment location and time. If the patient is to schedule the appointment, then make sure you include the timeframe by which the patient should schedule the appointment. (e.g. “Patient to arrange appointment time to be seen within two weeks.”)

*These categories are not necessary on off-service notes.