

UHN DISCHARGE SUMMARY TEMPLATE

Your dictated Discharge Summary should follow the template below. Include headings as they are appropriate:

1. Patient (Demographics)	
Patient Name	Patient's Name
Patient Identifier	Patient's hospital Medical Record Number (MRN)
Gender	Patient's Gender
2. Visit (Encounter)	
Admit Date	Date of Admission
Discharge Date	Patient's Date of Discharge
Discharge Diagnosis	Diagnosis most responsible for the patient's course in hospital. <i>If there is more than one such condition, the one held most responsible for the greatest portion of the length of stay or greatest use of resources</i>
Discharge Disposition	Location where the patient was discharged to. <i>e.g. Home, Home with Support Services, Transfer to Other Institution (named) or Death</i>
3. Diagnosis	
Pre-existing / Developed Conditions Impacting Hospital Stay	Patient condition(s) that coexist at the time of admission or developed post-admission and: <ul style="list-style-type: none"> • Requires treatment, or • Increases the length of stay by at least 24 hours (regardless of whether they were managed intensively during the stay, e.g. dementia), or • Significantly affects the treatment received
Conditions Not Impacting LOS	Pre-existing comorbidities or condition(s) that developed post-admission that did not affect the patient's length of stay
4. Course While in Hospital	
Presenting Complaint(s)	Symptom(s) for which the patient initially sought treatment and presented with
Summary Course in Hospital	Succinct summary of the patient's clinical course in hospital. Conclusion of associated investigation
Investigations	Succinct summary of examinations and tests conducted while in hospital
Interventions	Procedure(s) and/or treatments(s) carried out during course in hospital
5. Alert Indicators	
Allergies	If available, list all relevant allergies and describe reaction
6. Discharge Plan	
All Medications at Discharge	Home medications to be continued, home medications which have been adjusted or discontinued, and newly prescribed medications
Follow-up Instructions for Patient	Follow-up instructions for patient, including follow-up scheduled appointments, if applicable
Follow-Up Plan Recommended for Receiving Provider(s)	Investigations and interventions recommended to be conducted by the receiving provider after the patient has been discharged
Referrals	Referrals that have been initiated by the sender
Copies to be Sent to	Clinicians other than Primary Care/Referring Provider