# DISCHARGE SUMMARY TEMPLATE

**Approved by the Provincial HIM Leadership Committee March 19, 2010**

| **DEMOGRAPHIC AND ADMINISTRATIVE DATA** |
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| **PATIENT NAME** |
| **ADDRESS** |
| **CHART NUMBER** |
| **ACCOUNT NUMBER**<br>**(Meditech Registration Account Number)** |
| **HEALTH CARE NUMBER** |
| **DOB** |
| **GENDER** |
| **ADMISSION DATE** |
| **DISCHARGE DATE** |
| **REFERRING PHYSICIAN** |
| **MOST RESPONSIBLE PROVIDER (Attending physician)** |
| **FAMILY PHYSICIAN** |
| **ADMISSION DIAGNOSIS-**<br>Working diagnosis at time of admission (Do not use abbreviations.) |
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| **MOST RESPONSIBLE DIAGNOSIS (MRDx)**<br>The one diagnosis or condition that can be described as being most responsible for the patient's stay in hospital (Do not use abbreviations.) |
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| **PRE-ADMIT COMORBIDITY(IES)**<br>A condition(s) that coexists at the time of admission (Do not use abbreviations.) |
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| **POST- ADMIT COMORBIDITY(IES)**<br>A condition(s) that arises post-admission (Do not use abbreviations. ) |
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| **SECONDARY DIAGNOSIS(ES)**<br>A secondary diagnosis(es) or condition(s) which may or may not have received treatment but does not impact on the patient's LOS or treatment (Do not use abbreviations.) |
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| **INTERVENTIONS**<br>Diagnostic and/or Therapeutic interventions performed during the current episode of care |
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## HISTORY OF PRESENT ILLNESS

- Initial Presentation
- Chief Complaint
- Significant Findings
- Relevant laboratory results
- Allergies

## HOSPITAL COURSE

Events occurring during the current episode of care, e.g. treatment given, response to treatment/interventions, abnormal or significant test results, results pending, description of complications, consults, etc.

## CONDITION AT DISCHARGE

Provide comparison with condition at admission

## MEDICATIONS

- Admission Medications
- Changes made to regular medication regimen
- Medications prescribed upon discharge
- Drug Allergies
- Adverse Drug Reactions encountered during the admission

## DISCHARGE INSTRUCTIONS

- Diet
- Activities
- Medications
- Therapy
- Other instructions

## FOLLOW-UP

Arrangements for ongoing care

- Return appointments
- Referral to other services
- Discharge to (home, long term care, rehab, etc)

## SIGNATURE

- Physicians Signature
- Dictating Care Provider
- Date/Time Dictated
- Date/Time Transcribed
- Recipients of copies of the Discharge Summary

**References:**

Canadian Institute for Health Information. Canadian Coding Standards v2009 ICD-10-CA and CCI, Ottawa: Canadian Institute for Health Information, 2009

LaTour, Kathleen and Eichenwald, S. Health Information Management: Concepts, Principles, and Practice. American Health Information Management Association, Chicago, 2002

Physician Documentation Expert Panel. A Guide to Better Physician Documentation: What You Should Know About Physician Documentation. Toronto. November 2006

eHealth Ontario, Ontario Discharge Summary Implementation Guide, V 1.3 (Final Draft). Toronto, September 30, 2009

Canadian Health Information Management Association, Data for Electronic Patient Record Documentation, Professional Practice Brief – 0015.08. London, 2008

Klaus, Anne and Lariviere, Sandra, Physician Discharge Documentation.
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