Discharge Summary

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| **Name** |  |
| **Date of birth** |  |
| **Date of admission** |  |
| **Date of discharge** |  |
| **Reason for admission** |  |
| **Medical or psychiatric team responsible for care** |  |
| **Medications prescribed**  The medications the patient is intended to take after they have been discharged.  Record medicines prescribed at the time of discharge. The record should among else include:   * The generic name of the prescribed medication along with the dose and frequency of administration and Duration of treatment * Aids to compliance – where appropriate provide a description of any aids to compliance |  |

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| **Pertinent discharge information**  Significant information relating to the patient’s discharge plan which the discharging personnel wishes to convey to the primary care healthcare professionals and community services ***and*** details of the services the patient is currently engaged with |  |
| **Follow-up care instructions**  This should include any actions and recommendations that will be carried out by the hospital department; that are requested of the general practitioner; actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake; actions relating to the person’s social care that have been requested to be undertaken (e.g. key worker/case manager supporting patient to access follow up appointments). |  |
| **Summary of hospital stay** |  |