| Hospital Logo | **TEMPLATE FOR**
Preliminary Discharge Summary/Clinical Care Map
(It is imperative that all comorbidities and
interventions that affect Length of Stay (LOS)
must be documented.) | Patient Name:
MCP #
Chart #:

Addressograph |

Admission Date: _____ Predicted LOS: _____

Attending Physician: _____

Admitting Diagnosis: _____

Discharge Date: _____

To be completed by Medical Records:
Target LOS: _____ EDD: _____

Discharge Disposition: ☐ Home ☐ Other facility ☐ Deceased ☐ Against Medical Advice

Most responsible Diagnosis:	Did this affect LOS?
Pre-Admission Comorbidity (Primary Diagnosis):	☐ YES ☐ NO
Complications (Post Admission Comorbidity):	☐ YES ☐ NO
Secondary Diagnosis:	☐ YES ☐ NO

Clinical Care Map: Is the Patient Palliative? ☐ Yes ☐ No

Did the patient receive blood components or blood products? ☐ YES ☐ NO

Quantity (#units) transfused: RBC_____ Platelets _____ Plasma Products (Specify)_____

Blood Products: (Specify) _____For further information, contact family physician

Course in hospital: (Includes investigations therapies, interventions and consults)

Day 1: _____ Day 2 & 3: _____ Day 4 & 5: _____

Day 6 & 7: _____ Day 8 & 9: _____ Day 10 or greater: _____

Medications on Discharge: (Name of drug, frequency and route)

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10. _____

Activities: Resume: ☐Shower ☐ Tub Bath ☐Sponge Bath ☐Housework ☐ Drive Car ☐Climb Stairs ☐Sexual activity

Incision – If you develop any signs of infection such as redness, swelling or drainage, please contact your doctor and call phone # for Infection Control) leaving your name and telephone number for follow-up.

Comments:

Follow Up-Appointment: _____ Date: _____
(Diagnostic, Lab & Physician)

_____ Date: _____

Physician's Name: _____ _____ Date: _____
                        Print   Signature

For Medical Records Use: Discharge Summary Dictated: ☐ Yes ☐No Date: _____ Signed By: _____

Chart Assembled ☐ Chart Abstracted ☐ Chart Completed: ☐ Coder's Signature _____