

# PATIENT DISCHARGE INSTRUCTIONS AND SUMMARY OF CARE

## I. PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Unit Number (if applicable): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## II. HEALTHCARE FACILITY AND PROVIDER INFORMATION

Healthcare Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Unit Number (if applicable): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Discharging Provider Name: \_\_\_\_\_

Provider Contact Number: \_\_\_\_\_

## III. DISCHARGE DETAILS

Date of Admission: \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Date of Discharge: \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Procedure(s) Performed (if applicable): \_\_\_\_\_

Reason for Discharge: \_\_\_\_\_

**IV. SUMMARY OF CARE RECEIVED**

**A summary of the care and treatment provided during your stay/visit includes:**

---

---

---

---

---

**V. DISCHARGE CONDITION**

**Your condition upon discharge is:**

---

---

---

**VI. MEDICATIONS**

**A. New Medications:**

**Medication Name:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:**  
\_\_\_\_\_ **Special Instructions:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:**  
\_\_\_\_\_ **Special Instructions:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:**  
\_\_\_\_\_ **Special Instructions:** \_\_\_\_\_

**B. Changed Medications:**

**Medication Name:** \_\_\_\_\_ **Old Dosage:** \_\_\_\_\_ **New Dosage:**  
\_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Special Instructions:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Old Dosage:** \_\_\_\_\_ **New Dosage:**  
\_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Special Instructions:**  
\_\_\_\_\_

**C. Discontinued Medications:**

**Medication Name:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_

**D. General Medication Instructions:**

Take all medications exactly as prescribed. Do not stop taking medications without consulting your healthcare provider. If you experience any adverse reactions, contact your healthcare provider immediately.

**VII. ACTIVITY AND DIETARY INSTRUCTIONS**

**A. Activity Restrictions/Recommendations:**

- No restrictions
- Light activity only
- Avoid heavy lifting (over \_\_\_\_\_ lbs)
- Avoid strenuous exercise
- Rest as needed
- Specific instructions:

**B. Dietary Instructions:**

- No specific dietary restrictions
- Bland diet
- Low sodium diet
- Diabetic diet
- Clear liquid diet
- Specific instructions:

**VIII. WOUND CARE / DEVICE CARE (IF APPLICABLE)**

**A. Wound Care:**

Type of wound: \_\_\_\_\_

Dressing change frequency: \_\_\_\_\_

Supplies needed: \_\_\_\_\_

Instructions:

---

---

---

**B. Device Care (e.g., catheter, drain, ostomy):**

Type of device: \_\_\_\_\_

Care instructions:

---

---

---

## IX. SYMPTOMS TO WATCH FOR AND WHEN TO SEEK MEDICAL ATTENTION

Contact your healthcare provider or seek immediate medical attention if you experience any of the following: \* Fever greater than \_\_\_\_\_ °F ( \_\_\_\_\_ °C)

- \* Increased pain not relieved by prescribed medication
- \* Redness, swelling, warmth, or pus from any incision or wound site
- \* Nausea, vomiting, or inability to keep fluids down
- \* Shortness of breath or difficulty breathing
- \* Chest pain
- \* Sudden weakness or numbness
- \* Any other concerning or worsening symptoms:

## X. FOLLOW-UP APPOINTMENTS

### A. Scheduled Appointments:

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Time: \_\_\_\_\_ Location: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Time: \_\_\_\_\_ Location: \_\_\_\_\_

### B. Appointments to Schedule:

You need to schedule a follow-up appointment with: Provider/Specialty: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Provider/Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## XI. EMERGENCY CONTACT INFORMATION

In case of an emergency, call 911 or go to the nearest emergency room.

Nearest Emergency Room: \_\_\_\_\_

Emergency Room Phone Number: \_\_\_\_\_

## XII. PATIENT ACKNOWLEDGMENT

I, \_\_\_\_\_ (Patient Name), acknowledge that I have received and understand

these discharge instructions. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the importance of following these instructions for my recovery and well-being.

**Patient Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

### **XIII. PROVIDER CERTIFICATION**

**I certify that I have reviewed these discharge instructions with the patient or their authorized representative and believe they understand the instructions provided.**

**Discharging Provider Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

**Title:** \_\_\_\_\_