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. *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*
	Discharge Disposition	Location where the patient was discharged to. *e.g. Home, Home with Support Services, Transfer to Other Institution (named) or Death*
3.	**Diagnosis**	
	Pre-existing / Developed Conditions Impacting Hospital Stay	Patient condition(s) that coexist at the time of admission or developed post-admission and: • 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