Discharge/Death Summary Format

Policy

The medical record should be completed within 30 days after the patient is discharged. A closing summary, often referred to as the "Discharge Summary" must be dictated on each patient within 15 days after formal release from the Center, or after a patient's death, signed by the physician before the 30-day time frame from the date of release. The summary shall contain essential identifying information, dates, as well as a complete description of findings, case management, outcome, disposition, and post-release plan. When a patient dies, a summation shall be entered in the medical record in the form of a Discharge Summary. The summary shall include the circumstances leading to the death. Every summary must note the date and time the document was dictated, as well as the date the document was transcribed and the transcriber's initials.

Procedure

Since the closing summary is one of the most important entries in the medical record, special care should be taken to see that all information is accurate, clear, and concise. The summary should make it unnecessary to have to search a record to find essential information regarding the patient's diagnoses, care, and disposition. It should always contain:

A. Identifying Information: This should include the race, sex, age, marital status, date and type of admission, legal status on admission and discharge.

The document will be subdivided with underlined headings:

B. Reason for Admission:

Reason must include the circumstances leading to admission, chief complaint and presenting problems, symptoms, and signs. They must fall within Criteria for Appropriate Admission, as approved by the Utilization Review Committee.

C. Condition at Admission:

1. Presenting problems, symptoms, and signs.
2. Mental Status

D. Provisional Diagnoses or Impression at admission:

a. Psychiatric Disorders
b. Personality/Developmental Disorders
c. Substance Use
d. Somatic Disorders

E. Course in Hospital, Treatment & Outcome: Enable any subsequent clinician to know that problems arose, what was helpful, and what was not helpful. For example:

1. Hospital adjustment and behavior
2. Problems of patient management
3. Complications, if any
4. Significant incidents or accidents
5. Medical conditions that arose during hospitalization
6. Change in symptoms
7. Treatment modalities and response to various treatments
8. Medications-range of dosage and reaction to medication
9. Education or training received
10. Case Management in general

F. Condition at Release:

1. Full mental status and physical condition at release
2. Unresolved problems

G. Functional Capacity:

1. Ability to care for self
2. Competency to manage funds
3. Ability to resume previous work activities (must state whether able to resume previous type of work modifications or still unable)

H. Risk Assessment:

Overall summary of current factors that benefits the patient to reduce the risks, such as compliance to treatment, substance abuse-free lifestyle, support in the community and clinical stability.

I. Release Plan and Follow-up Aftercare. Recommendations or specific plans made as indicated for:

1. Management of problems remaining unresolved
2. Medical follow-up for treatment or further diagnostic work, if indicated
3. Prevention of further difficulties or relapse, e.g., necessity of continued medications, supportive psychotherapy, or management

4. Referral to family physician, psychiatric clinic, special school, school agencies, etc.
5. Education and training
6. Living and working arrangements
7. Conference with and instructions to the following, if appropriate:
    a. The patient and his/her family
    b. Professional workers who will assist patient and/or family
    c. Court personnel (as appropriate)
8. Final Medications, dosage, frequency, and instructions for use
9. Diet, activities, and restrictions if any
10. Notation of presence or absence of allergies

J. Final Diagnoses:

Diagnoses shall be listed as follows:

Psychiatric Diagnoses (Clinical Syndrome and V Codes).

Personality Disorders & Developmental Disorders

Substance Use Related Disorders

Physical Disorders & Conditions*

*Do not include minor ailments which the patient may have had through a long hospitalization, and which has been successfully treated prior to release.

Rule out and deferred diagnoses should not be used in Discharge Summaries.

Approved by

6/27/24__
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6/27/24__
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MRA/tg

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