Schedule – C

STANDARD DISCHARGE SUMMARY:

1. Components of Standardization:
   a. List of standard contents in the discharge summary
   b. Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the documents and the information provided is uniform.
2. Standard Contents of Discharge Summary Format:
   a. Patient's Name*:
   b. Telephone No / Mobile No*:
   c. IPD No:
   d. Admission No:
   e. Treating Consultant/s Name, contact numbers and Departments/Specialty:
   f. Date of Admission with Time:
   g. Date of Discharge with Time:
   h. MLC No / FIR No*:
   i. Provisional Diagnosis at the time of Admission:
   j. Final Diagnosis at the time of Discharge:
   k. ICD – 10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*:
   l. Presenting Complaints with Duration and Reason for Admission:
   m. Summary of Presenting Illness:
   n. Key findings, on physical examination at the time of admission;
   o. History of alcoholism, tobacco or substance abuse, if any:
   p. Significant Past Medical and Surgical History, if any*:
   q. Family History if significant/relevant to diagnosis or treatment:
   r. Summary of key investigation during Hospitalization*:
   s. Course in the Hospital including complication if any*:
   t. Advice on Discharge*:
   u. Name & Signature of treating Consultant / Authorized Team Doctor:
   v. Name & Signature of Patient / Attendant*:

* refer to guide notes below.

3. GUIDE NOTES FOR FILLING DISCHARGE SUMMARY FORMAT:

   a. The patient's name shall be the official name as appearing in the insurance policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the

attendants give the nick names which are different from documented names. As a matter of abundant precaution, all personal information should be shown to the patient/attendant and validated with their signature.

b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.

c. Where applicable, copy of MLC/FIR needs to be attached

d. Responses to point (2) (b), (k) and (p) are desirable but not mandatory

e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same.

f. Summary of key investigations shall appear chronologically consolidated for each type of investigation. If an investigation does not seem to be a logical requirement for the main disease/line of treatment, the admitting consultant should justify the reason for carrying out such test / investigation.

g. The course in the hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the hospital, the same should be specified. If opinion from another doctor from outside hospital is obtained, reason for same should be mentioned and also who decided to taken opinion i.e. whether the admitting and treating consultant wanted the opinion as additional expertise or the patient relatives wanted the opinion for their reassurance.

h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.

i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases like Death summary or transfer notes in case of terminal illness, the attendant can sign. In such cases, the inability of the patient to sign should be recorded by the attending doctor.